Benchmark Equivalent Coverage Analysis

Healthy Indiana Plan Demonstration

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BACKGROUND

This report was developed in response to a request from the Center for Medicare and Medicaid Services (CMS). In a February 15, 2013 letter, Diane Heffron requested a benefit analysis of the Healthy Indiana Plan (HIP) section 1115 demonstration.

CMS will use this benefit analysis to determine whether coverage provided under HIP as of December 1, 2009 represented "full benefits", "benchmark", or "benchmark-equivalent" coverage.

The performance of this benefit analysis will not obligate Indiana to expand Medicaid.

Details of CMS' request are included in Attachment A to this report. The report is structured in the same manner as the request.

SECTION 1 – BENEFIT ASSESSMENT TO SUBSTANTIATE NEWLY ELIGIBLE

The newly eligible FMAP is only available to states that, as of December 1, 2009, did not provide "full state plan benefits", "benchmark", or "benchmark-equivalent" coverage to low-income adults in the new adult coverage group, either through the Medicaid state plan or through a section 1115 demonstration.

As of December 1, 2009, the state provided coverage to uninsured custodial parents and caretaker relative adults (ages 19 through 64) with income above the AFDC income limit up to and including 200 percent of the federal poverty level (FPL) and uninsured non-custodial parents and childless adults (ages 19 through 64) with family income up to and including 200 percent of the federal poverty level (FPL).

Coverage was provided through the Healthy Indiana Plan (HIP) demonstration (Project Number 11-W-00237/5).

1. ENROLLMENT LIMIT

As of December 1, 2009, the demonstration Special Terms and Conditions restricted enrollment for non-custodial parents and childless adults to 34,000. There was no specific enrollment cap for custodial parents and caretaker relatives; although, the state was allowed to modify eligibility if funding was not available.

2. FULL BENEFITS

The benefits available under the HIP 1115 demonstration, as in effect December 1, 2009, did not include all benefits available under the state's approved Medicaid plan. For example, HIP did not cover maternity benefits, vision benefits, dental benefits, Medicaid rehabilitation option services, chiropractic benefits, hearing aids, non-emergency transportation benefits, and others. In addition, benefit limitations often differed from those in the state plan.

HIP benefits were subject to annual and lifetime limits of $300,000 and $1,000,000 respectively. In addition, enrollees were required to make monthly contributions to a POWER account. Those who did not make required contribution were dis-enrolled.

3. BENCHMARK COVERAGE

The benefits available under the HIP 1115 demonstration, as in effect December 1, 2009, did not represent "benchmark coverage", as described in subparagraph (A), (B), or (C) of section 1937(b)(1) of the Act.

The demonstration did not include the entire range of services offered under the three benchmark commercial packages, as in effect December 1, 2009.

The Standard BCBS PPO, as offered under the FEHBP

The demonstration did not include the entire range of service offered under the Federal Employees Health Benefit Program (FEHBP), as in effect December 1, 2009. The demonstration did not include maternity services, chiropractic services, vision services, or dental services.

In addition, HIP benefits were subject to annual and lifetime limits of $300,000 and $1,000,000 respectively. Although the FEBHP plan contains lifetime maximum benefits for specific services (for example wigs or substance abuse treatment), there is no overall lifetime maximum benefit limit.

The State Employee PPO

The demonstration did not include the entire range of service offered under the State employee PPO, as in effect December 1, 2009. The demonstration did not include maternity services, chiropractic services, vision services, or dental services.

In addition, HIP benefits were subject to annual and lifetime limits of $300,000 and $1,000,000 respectively. The State Employee PPO has no annual limit, but has a lifetime benefit limit of $2,000,000 per member.

The HMO with the largest insured non-Medicaid enrollment

The demonstration did not include the entire range of service offered under the Advantage HMO, as in effect December 1, 2009. The demonstration did not include maternity services, vision services, or dental services.

In addition, HIP benefits were subject to annual and lifetime limits of $300,000 and $1,000,000 respectively. The Advantage HMO does not have an overall lifetime maximum benefit limit.

4. BENCHMARK EQUIVALENT COVERAGE

The benefits available under the HIP 1115 demonstration, as in effect December 1, 2009, did not represent "benchmark coverage", as described in section 1937(b)(2) of the Act.

Inclusion of Basic Services

i. Inpatient and outpatient hospital
   The demonstration package covered most inpatient and outpatient hospital services. However, Maternity services were not covered under HIP.
ii. Physicians' surgical and medical services
   The demonstration package covered physician services.
iii. Lab and x-ray services
   The demonstration package covered lab and x-ray services.
iv. Emergency services, as required in 42 CFR 440.335(b)(5)
   The demonstration package covered emergency services, as required in 42 CFR 440.335(b)(5).

42 CFR 440.335(b)(5) requires benchmark benefit packages to include coverage of essential health benefits. Please note that « Maternity and newborn care » is listed as an essential health benefit under Section 1302(b)(1)(D) of the Patient Protection and Affordable Care Act.

HIP also provides only limited coverage of another essential benefit: "Rehabilitative and Habilitative services and devices" (ACA Section 1302(b)(1)(G)). For example, HIP does not cover hearing aids, safety glasses, athletic glasses, treatment for learning disabilities, or foot care.

Aggregate Actuarial Value

The study developed an aggregate actuarial value for the Healthy Indiana Plan demonstration and each of the three benchmarks. The actuarial values are illustrated in Table 1 below.

Table 1 Actuarial Value – Aggregate Plan Healthy Indiana Plan Demonstration compared with benchmarks	
Plan	**Actuarial Value**
Standard BCBS PPO	83%
State employee plan	86%
Largest HMO	83%
HIP Demonstration	75%

The aggregate actuarial value of the demonstration is lower than all three benchmarks. The difference is larger than the +/- 2% *de minimis* standard to be used on Affordable Insurance Exchanges.

Prescription Drugs, Mental Health, Vision, or Hearing services

The actuarial value of prescription drug, mental health, vision, and hearing benefits provided by the Healthy Indiana Plan demonstration was compared to each of the three benchmarks. The actuarial values are illustrated in Table 2 below.

Table 2 Actuarial Value for Specific Services Healthy Indiana Plan Demonstration compared with benchmarks				
Plan	**Drug**	**Mental health**	**Vision**	**Hearing**
Standard BCBS PPO	82%	73%	82%	89%
State employee plan	93%	83%	82%	78%
Largest HMO	82%	54%	82%	100%
HIP Demonstration	100%	100%	0%	100%

The actuarial value calculated for each service is illustrated net of service-specific cost sharing such as copays and coinsurance, but before application of global cost sharing such as deductibles and out of pocket maximums.

The benchmark plans all include at least a basic level of vision services that allows for coverage of eyeglasses when related to an injury or specific medical condition. The demonstration does not cover vision services under any circumstances. Under section 1937(b)(2)(C) of the Act, vision service coverage for benchmark equivalent plans is required to have an actuarial value that is at least 75% of the benchmark.

The benchmark plans all make subsidized optional dental and vision plans available to members, but these optional plans have not been included in our analysis.

Actuarial Value Calculation

Milliman has provided a certificate of actuarial value of the demonstration benefit package as part of this report. The analysis conforms to the following guidelines:

i. The study was performed in accordance with generally accepted actuarial principles and methodologies. All Actuarial Standards of Practice promulgated by the Actuarial Standards Board have been observed.
ii. The study uses a standardized set of utilization and price factors for the demonstration plan and the benchmarks. The utilization is representative of an adult population and Medicare pricing was used.
iii. The study uses a standardized population for evaluating the demonstration plan and the benchmarks. In order to be representative of the potential new adult coverage group, an adult non-Medicare population was used, with an age and gender distribution similar to that of the population that would be eligible for the new adult coverage group in Indiana. Coverage is assumed to be self-only (no family or dependent coverage).
iv. The demonstration was compared to the benchmarks using the same principles and factors in comparing the value of different coverage. The same actuarial cost model was used for all plans, modified only to reflect different plan provisions, such as benefits covered and cost sharing provisions.
v. The analysis does not take into account any differences in coverage based on method of delivery or means of cost control or utilization used.
vi. The analysis reflects cost sharing requirements for each plan.

Appendix B contains actuarial cost model summaries for the HIP demonstration and each benchmark plan.

Data

CMS suggested actual claims experience from the demonstration population be used as a data source for the average utilization and cost information needed to determine actuarial value. Milliman's preliminary analysis explored this option, and identified two issues with this approach:

- The enrolled demonstration population is not representative of those who would be eligible for the new adult coverage group under a Medicaid expansion. The demonstration population is significantly older, more female, and less healthy than the population eligible for the new adult coverage group.
- The demonstration claims data does not include utilization for essential health benefits that were not covered by the demonstration benefit package. For example, because HIP does not cover benefits such as maternity care or vision, utilization of such benefits in the demonstration claims data is zero. This does not allow us to estimate the actuarial value of these benefits for benchmark plans that offer these services.

The alternative we chose was to use ***Milliman Health Cost Guidelines*** data.

The ***Guidelines*** were first developed by Milliman in 1954, and have been updated and expanded annually since that time. An extensive amount of data is used in developing the Guidelines, including published and unpublished data. The ***Guidelines*** was developed from full medical experience (hospital, physician, supplies, prescription drugs) from over 21 million lives. This is supplemented by other sources for specific services, for example a database of inpatient admissions that represents 75% of the national total.

Base utilization levels in the ***Guidelines*** are consistent with a commercial major medical plan. The utilization is summarized by age and gender, and is easily adjusted to the approximate age and gender makeup of those eligible for the new adult coverage group. Utilization is available for every service that may be offered by a benchmark plan.

Methodology

The actuarial value of the HIP demonstration and each benchmark plan was developed using a common actuarial cost model. High level results from this model are illustrated in Appendix B. The summaries illustrate all the key elements by category of service: utilization, cost per service, per member per month cost, and cost sharing value. For each service, the model illustrates estimated utilization (column 1) and average allowed cost per service (2). These are multiplied to develop the total per member per month (3) cost of benefits for each service. Through column 3, the results are identical for the demonstration and three benchmark plans. The total per member per month cost of $280.52 represents the cost

of essential health benefit coverage for the standardized population at a Medicare reimbursement. This is the denominator for each aggregate actuarial value calculation.

Column 4 illustrates the value of member cost sharing. As an example, when the plan requires the member to contribute 20% coinsurance, the cost sharing will be approximately 20% of the total value in column 3. In cases where the benefit was not covered in December 2009, the cost sharing will be equal to the total value in column 3 (for example maternity benefits for the demonstration). Column 5 illustrates the net value provided by the plan. The net per member per month cost for all services is developed by adding the cost for each individual service.

Finally, cost sharing provisions that apply across multiple service categories, such as deductibles or out of pocket maximums, are reflected. After adjustment for global cost sharing, the net per member per month cost illustrates the value provided by the plan.

The actuarial value for each plan is developed by dividing the value of benefits provided by the plan by the total per member per month cost for covering all essential health benefits ($280.52).

Demographics

The cost models used standard utilization, developed based on the ***Milliman Health Cost Guidelines*** data, with adjustment for the estimated demographics of the new adult coverage group in Indiana. This group is aged 19 to 64, with age and gender distribution as illustrated in Table 3 below.

Table 3
Age/Gender Distribution - New Adult Coverage Group

Age Bracket	Male	Female
19-25	12%	11%
25-29	6%	6%
30-34	5%	6%
35-39	4%	5%
40-45	4%	6%
45-49	4%	4%
50-54	5%	4%
54-59	3%	4%
60-64	4%	6%

Those eligible for the new adult coverage group were estimated based on 2011 American Community Survey data from the U.S. census bureau. We selected individuals aged 19 – 64 who were not already covered by Medicare or Medicaid and had incomes below 138% of poverty guidelines. Also excluded were individuals in group quarters: college students, nursing home residents, and incarcerated individuals. We have found that college students often appear to have improperly low incomes because they have not been grouped with their parents. And finally, the estimated new adult coverage group also excludes adults who are currently eligible for Medicaid but enrolled: custodial adults with incomes below the AFDC income limits.

Pricing and Other Assumptions

Pricing in the models has been adjusted to Medicare levels for all plans. This is the pricing level used for the HIP demonstration. Pharmacy reimbursement has been assumed to be the Average Wholesale Price (AWP) less 18% for brand name drugs, and AWP less 65% for generics. A $2 dispensing fee has also been incorporated in the cost.

No adjustment has been made to reflect differing degrees of health care management, including utilization control, prior authorizations, or other delivery system variations.

Cost sharing provisions for each plan are reflected in the models.

Analysis of Results

In general, the benchmark plans covered a wider range of services, most notably maternity benefits.

Adjustments for the value of the cost sharing did not change the relative positions of the plans. Although the benchmark plans have higher copays and coinsurance, the demonstration has the highest deductible.

The remainder of this section discusses the actuarial value by category of service. Please refer to the actuarial cost model summaries in Appendix B.

Inpatient Facility benefits

As for all services, utilization (column 1), average allowed cost (2) and total per member per month cost (3) are the same for all plans. The total monthly value of these services before cost sharing is estimated as $46.09 for all plans.

The benchmark plans had relatively low cost sharing for this category of service:

- The FEHBP required a $200 copay per admission. The copay is waived for maternity admissions.
- The State employee plan required a $500 copay per admission.
- The HMO required a $250 copay per admission.
- The HIP demonstration did not cover maternity services. This is illustrated as 100% cost sharing for this service line. There are no other copay or coinsurance requirements for inpatient hospital services. However, these services were subject to the $1,100 deductible.

Outpatient Facility benefits

The total monthly value of outpatient facility services before cost sharing is estimated as $60.18 for all plans.

Cost sharing is reflected as follows:

- The FEHBP required 15% coinsurance
- The State employee PPO required $75 copays for emergency room services, $250 copays for outpatient surgery, and 20% coinsurance applied to other services.
- The HMO required $125 copays for outpatient surgery and emergency room visits, $35 copays for therapy, mental health, and substance abuse visits, and an additional $50 copay for certain types of imaging. Other services were subject to 20% coinsurance.
- The HIP demonstration required a $3 to $25 copay for emergency room services. Also, all costs other than preventive services were subject to the deductible.

Professional

The total monthly value of professional services before cost sharing is estimated as $76.41 for all plans.

Cost sharing generally reflected a mixture of copays and coinsurance and can be summarized as follows:

- The FEHBP required $20 copays for most office visits, and 15% coinsurance for other services. Cost sharing was waived for maternity services.
- The State employee PPO required $20 copays for office visits, and 20% coinsurance applied to other services. Cost sharing was waived for preventive services.
- The Advantage HMO did not cover chiropractic services. These are illustrated as 100% patient responsibility. In general, the HMO applied $20/$35 primary care/specialist copays to office visits, including mental health and substance abuse visits, with $50 copays for urgent care visits. 20% coinsurance applied to other services. Cost sharing is reduced for maternity services (only applies to the first prenatal visit).
- The HIP demonstration did not cover maternity or chiropractic services. These are illustrated as 100% patient responsibility. Also, all costs other than preventive services were subject to the $1,100 deductible.

Other

The total monthly value of professional services before cost sharing is estimated as $97.84 for all plans, mainly attributable to prescription drugs.

Prescription drug cost sharing provisions can be summarized as follows:

- When purchased retail, the FEHBP required 20% coinsurance for generics and 30% for brand drugs. Mail order purchases allowed for a 90-day supply: $10 for generics and $65 for brand name drugs. We have assumed an even mix of purchase types (mail order/retail).
- The State employee PPO required $10 copays for generic drugs, $20 for brand drugs.
- The Advantage HMO required $10 or $20 copays for generic drugs and $30 for brand drugs.
- The HIP demonstration had no copays for drugs. They were subject to the $1,100 deductible.

The HIP demonstration did not provide dental or vision benefits. The benchmark plans covered a minimal level of vision and dental benefits in order to cover accidental injury or glasses needed for a medical condition. The benchmark plans also subsidize stand-alone supplemental vision and benefit plans for members, but these are not valued as part of this analysis.

Global Cost Sharing Adjustments

The value of global cost sharing provisions, such as deductibles and out of pocket maximums, was developed using a claims probability distribution. Although average per member per month values are illustrated for each service, the majority of members do not incur any claims at all during a given month, and those members who do incur claims tend to incur costs that are higher than the average.

The deductible serves to shift a portion of first dollar costs from the plan to the member, reducing actuarial value. It has a greater impact for HIP demonstration members than for benchmark plan members. This is because:

- Except for preventive services, all demonstration services are subject to the deductible. The benchmark plans have many commonly provided services, most notably hospital, prescription drugs and office visits, that are not subject to the deductible because they are subject to copays instead.
- The demonstration's deductible is higher than for the other plans.

The out of pocket maximum serves to protect members who incur large costs, adding to the value of the plan. The value of this provision is largest for the State PPO, as their members only have to incur $2,000 in out of pocket expenses - $500 deductible plus $1,500 additional – before the out of pocket maximum kicks in. It is less valuable for the FEHBP, whose members need to pay $5,000 out of pocket before the maximum is reached. And it has almost no value at all for HIP demonstration members because after the $1,100 deductible has been paid, there are no additional opportunities for cost sharing (no other copays or coinsurance except for a minimal copay related to emergency services.)

SECTION II – BENEFIT ASSESSMENT TO SUBSTANTIATE EXPANSION STATE FMAP

In the previous section, the State of Indiana has determined that the Healthy Indiana Plan (HIP) section 1115 demonstration did not provide full benefits, benchmark benefits, or benchmark equivalent benefits. The State has not prepared a response to Section II due to the results of the analysis presented in Section I.

CERTIFICATE OF ACTUARIAL VALUE OF THE DEMONSTRATION PACKAGE

ACTUARIAL CERTIFICATION

The authors of this study, Robert Damler, and Christine Mytelka, are consulting actuaries with the firm of Milliman, Inc. We were retained by the State of Indiana, Office of Medicaid Policy and Planning, to perform a benchmark equivalent coverage analysis for the Healthy Indiana Plan (HIP) demonstration.

The study was performed in accordance with generally accepted actuarial principles and methodologies. All Actuarial Standards of Practice promulgated by the Actuarial Standards Board have been observed.

The study uses a standardized set of utilization and price factors for the demonstration plan and the benchmarks. The utilization is representative of an adult commercial population, and Medicare pricing was used.

The study uses a standardized population for evaluating the demonstration plan and the benchmarks. A non-Medicare adult population was used, with standard age and gender distribution. Coverage is assumed to be self-only (no family or dependent coverage).

The demonstration was compared to the benchmarks using the same principles and factors in comparing the value of different coverage. The same actuarial cost model was used for all plans, modified only to reflect different plan provisions, such as benefits covered, benefit limitations, and cost sharing provisions.

The analysis does not take into account any differences in coverage based on method of delivery or means of cost control or utilization used.

The analysis reflects the increase in actuarial value of benefits resulting from limitations on cost sharing.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

March 26, 2013
Date

Christine Mytelka, FSA, MAAA
Consulting Actuary

March 26, 2013
Date

LIMITATIONS

The information contained in this report has been prepared for the State of Indiana, Family and Social Services Administration and Office of Medicaid Policy and Planning (OMPP), to assist with submitting benefit information associated with the Healthy Indiana Plan 1115 demonstration to the Centers for Medicare and Medicaid Services (CMS). The data and information presented may not be appropriate for any other purpose.

The letter may not be distributed to any other party without the prior consent of Milliman. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for OMPP by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by the State of Indiana, Family and Social Services Administration and their vendors. The values presented in this letter are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented in our report will need to be reviewed for consistency and revised to meet any revised data.

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and OMPP approved May 14, 2010.

Appendix A

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

FEB 15 2013

Patricia Casanova
Director
Office of Medicaid Policy and Planning
Family and Social Services Administration
402 West Washington Street, PO Box 7083
Indianapolis, IN 46207-7083

Dear Ms. Casanova:

CMS recently issued Questions and Answers, which can be found at http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/ACA-FAQ-BHP.pdf, to provide states with more information about the availability of increased federal medical assistance percentages (FMAPs, or federal match) provided in the Affordable Care Act. We are writing to provide additional guidance to Indiana on the availability of the "newly eligible" and/or "expansion state" FMAP given that Indiana provided coverage to low-income adults through its Healthy Indiana Plan (HIP) section 1115 demonstration prior to the enactment of the Affordable Care Act. Specifically, we wanted to describe how we will work with you to determine whether demonstration populations will be eligible for the newly eligible, expansion state or regular FMAP, if your state decides to adopt the new adult coverage group. More guidance about the method states will use to distinguish among populations for purposes of applying the appropriate FMAP will be provided in forthcoming FMAP final regulations.

As you know, beginning in 2014 the Affordable Care Act authorizes two types of increased federal Medicaid matching rates for state expenditures for low-income individuals in the new adult group (that is, the group described by section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act)): the newly eligible FMAP and the expansion state FMAP. Under the statute, these two increased federal matching rates are only available to states that adopt the new adult group.

- The newly eligible FMAP is available to all states, including those identified as expansion states, for expenditures for individuals in the new adult group who would not be eligible for full state plan, benchmark, or benchmark-equivalent Medicaid benefits under state rules in effect as of December 1, 2009. This includes expenditures for individuals that would have been eligible for such coverage, but were not enrolled due to enrollment limitations under the demonstration.
- The expansion state FMAP is available to qualifying states for expenditures for certain nonpregnant childless adults (those who are enrolled in the new adult group and who the state may require to enroll in benchmark coverage), to the

> extent that such individuals do not qualify for the newly eligible FMAP. A qualifying state is a state that, as of March 23, 2010 (the date of enactment of the Affordable Care Act), had provided a specified level of health benefits coverage, which we refer to as "specified" coverage,[1] (whether through Medicaid or a fully state-funded program) statewide to both low-income parents and nonpregnant childless adults up to at least 100 percent of the federal poverty level (FPL).

The newly eligible and expansion state FMAP definitions reference different coverage dates and different scopes of benefits, thus requiring different analyses to confirm their application. To the extent that the definitions overlap for a particular population, so that either the newly eligible or the expansion state FMAP could apply in a state designated as an expansion state, expenditures would be matched at the higher applicable FMAP; being an expansion state will not be a disadvantage in terms of matching rates for that population. It is important to also note that the expenditures for some populations in the new adult group (for example, parents who were previously eligible for full state plan benefits) may be matched at your regular FMAP.

We will work with you and your staff to ensure that the correct FMAP is applied to expenditures for each population. When we approved the HIP demonstration, we did not explicitly designate the coverage offered under your accepted Special Terms and Conditions (STCs) as "benchmark" or "benchmark-equivalent" coverage, even though the coverage offered to demonstration beneficiaries may have met such standards. Therefore, to reach a final FMAP determination for your state, we are requesting that you provide certifications about eligibility and benefits in effect as of dates specified in the Affordable Care Act.

In particular, we request that you provide a benefit analysis that includes the information described in Attachment A to enable CMS to confirm whether coverage provided to each demonstration population as of December 1, 2009 represents "full benefits," "benchmark," or "benchmark-equivalent" coverage. (Additional information on the statutory benchmark standards that were in effect on December 1, 2009 can be found at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/Benchmark-Standards-12-1-09.pdf). If the demonstration coverage is found not to have met a benchmark or benchmark-equivalent coverage standard, Indiana will qualify for the newly eligible FMAP for relevant populations. As noted above, Attachment A provides a guide for you and your staff to use to as you conduct your benefit analyses. Completion of the guide is not required as it is merely a form to use at your option; however, the type of information contained in it is needed for CMS to confirm your applicable FMAPs.

If the newly eligible FMAP is not available for a particular population, you may be able to claim the expansion state FMAP for certain nonpregnant childless adults covered in

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[1] The standards for specified coverage are set forth in section 1905(z)(3) of the Act statewide; it is coverage that included inpatient hospital services, was not dependent on access to employer coverage, employer contribution, or employment, and was not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits authorized under a demonstration program authorized under section 1938 of the Act.

the new adult group. The benefit analysis described in Attachment A is necessary for you to establish Indiana's status as an expansion state so that we can apply the expansion state FMAP to appropriate expenditures. As noted above, status as an expansion state will not negatively affect your ability to claim the newly eligible FMAP. The expansion state FMAP will apply only when the newly eligible FMAP is not applicable for a particular population.

Attachment A provides additional detail about the methodology and data necessary to substantiate your analysis. For example, the state's benchmark equivalence analyses must be certified by a qualified actuary and must include information on the data, assumptions, and methodology used to calculate actuarial values, as described in Attachment A. We will use the benefit analyses information provided to determine the appropriate FMAP. Upon reviewing your benefit analyses, we may seek additional information and/or clarification.

Given that Indiana expanded coverage prior to the enactment of the Affordable Care Act, we encourage you to analyze your demonstration's benefits using the guide found in Attachment A and to submit your analyses to CMS. We understand that you may have not made a decision about whether and/or when to adopt the new adult coverage category and submission of your analysis will not obligate Indiana to any particular decision. Rather, providing this information will enable CMS to provide you with information about the FMAP(s) that might apply depending on the state's decision.

We are committed to reviewing your information and working with you and your staff to confirm the applicable FMAPs in a timely manner. We encourage you to submit your analysis to Allison Orris at Allison.Orris@cms.hhs.gov by April 15, 2013. Please work with your State Operations and Technical Assistance (SOTA) team, or contact Allison Orris if you have any questions.

Sincerely,

Dianne E. Heffron
Director
Financial Management Group

Attachment

Attachment A: Guide to Demonstration Benefit Analysis

cc:

Verlon Johnson, Associate Regional Administrator, Division of Medicaid and Children's Health Operations

Barbara Edwards, Director, Disabled and Elderly Health Programs Group

Jennifer Ryan, Acting Director, Children and Adults Health Programs Group

Attachment A - Guide to Demonstration Benefit Analysis

This Attachment provides a guide for the state to use to conduct the benefit analysis for purposes of determining which FMAPs may apply for adult populations provided coverage through section 1115 demonstrations prior to enactment of the Affordable Care Act. Use of this guide is not required; however, the information contained below will help CMS to confirm the applicable FMAPs. A separate analysis should be undertaken for each demonstration group, if different demonstration populations received different benefits under the demonstration and/or if different enrollment caps or limitations applied to different groups. CMS may request additional information to address specific questions; the below questions represent a uniform starting point for analysis.

Section I – Benefit Assessment to Substantiate Newly Eligible FMAP

The newly eligible FMAP is only available to states that did *not* provide "full state plan benefits," "benchmark" or "benchmark-equivalent" coverage to low-income adults either through the Medicaid state plan or through a section 1115 demonstration. To determine if demonstration-based coverage could have been designated as benchmark or benchmark-equivalent coverage, the following questions (based on section 1937 of the Act, as it was in effect on December 1, 2009, and our regulation at 42 CFR 440.330-340) should be considered as part of the state's analysis.

> According to our preliminary review, on December 1, 2009, the state provided coverage to uninsured custodial parents and caretaker relatives with income above the AFDC income limit up to and including 200 percent of the federal poverty level (FPL) and uninsured non-custodial parents and childless adults (ages 19 through 64) with family income up to 200 percent of the FPL through the Healthy Indiana Plan demonstration (Project Number 11-W-00237/5). If this is incorrect, please provide the correct demonstration name, project number and/or covered populations.

1. Was the demonstration, as in effect on December 1, 2009, authorized to limit enrollment?

> If applicable, please specify the enrollment cap authorized by the demonstration as of December 1, 2009, and the actual enrollment, as calculated per the reporting requirements specified under the demonstration, if different.

2. **Full Benefits:** Did the benefits available under the section 1115 demonstration indicated above, as in effect on December 1, 2009, represent "full benefits" meaning, with respect to each demonstration group, medical assistance for all services covered under the state's approved Medicaid state plan?

[If the answer to question 2 is "yes," skip to Section II to establish whether "expansion state" status is applicable.]

3. **"Benchmark Coverage":** Did the benefits available under the section 1115 demonstration indicated above, as in effect on December 1, 2009, represent "benchmark coverage" described in subparagraph (A), (B), or (C) of section 1937(b)(1) of the Act? Please answer the following questions to support this representation, and include any applicable citations to the demonstration's special terms and conditions (STCs) that were in effect on December 1, 2009:

3a. Did the demonstration benefit package include the entire range of services offered under any of the following three commercial products, as they were in effect on December 1, 2009? (States that are unable to locate health plan information from 2009 should contact CMS for technical assistance.)

i. The standard Blue Cross/ Blue Shield preferred provider option;
ii. A health benefits coverage plan that is offered and generally available to state employees in that state; or
iii. The health insurance coverage offered by a Health Maintenance Organization with the largest insured non-Medicaid enrollment of covered lives.

[If the answer to question 3a is "no," continue to question 4.]

4. **"Benchmark Equivalent Coverage":** Did the benefits available under the section 1115 demonstration indicated above, as in effect on December 1, 2009, represent "benchmark equivalent coverage" described in section 1937(b)(2) of the Act that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in (A), (B), or (C) of section 1937(b)(1) of the Act? Please answer the following questions to support this representation:

4a. Did the demonstration benefit package provide all of the following services?

i. Inpatient and outpatient hospital,
ii. Physicians' surgical and medical services,
iii. Lab and x-ray services, and
iv. Emergency services, as required in 42 CFR 440.335(b)(5)

4b. In addition to the services mentioned above, did the demonstration benefit package have an aggregate actuarial value that is at least actuarially equivalent to one of the three following commercial products:

i. The standard Blue Cross/ Blue Shield preferred provider option;
ii. A health benefits coverage plan that is offered and generally available to state employees in that state; or
iii. The health insurance coverage offered by a Health Maintenance Organization with the largest insured non-Medicaid enrollment of covered lives.

4d. If the commercial product selected for actuarial comparison contained prescriptions drugs, mental health services, vision or hearing services as of December 1, 2009, did the demonstration benefit package offer such coverage to have an actuarial value of at least 75 percent of the actuarial value of the coverage

for that category of service in the benchmark plan used for comparison by the state?

4e. Has the state obtained a certificate of actuarial value of the demonstration benefit package adhering to the requirements above, completed by an individual who is a member of the American Academy of Actuaries, and that meets the following elements?

i. Uses generally accepted actuarial principles and methodologies;
ii. Uses a standardized set of utilization and price factors;
iii. Uses a standardized population that is representative of the population involved;
iv. Applies the same principles and factors in comparing the value of different coverage (or categories of services);
v. Does not take into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
vi. Takes into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under this title that results from the limitations on cost sharing under such coverage. This is important especially since Medicaid typically has minimal or no cost sharing requirements (even if they may be more extensive in waiver plans) while the benchmark plans may have higher levels of cost sharing.

In conducting the foregoing analysis, it will be important to utilize a consistent methodology and provide CMS with sufficient data to substantiate the states' conclusions. Following the below guidelines will assure CMS' ability to validate states' analysis:

- The analysis should specify the source of data used to calculate the actuarial value of the plans. We recommend using recent actual claims experience from beneficiaries in the demonstration to conduct the analysis. If other data is used, the data should be for a comparable population (which may include age, gender, geography, and health and disability status amongst other factors); the report should also state why this data source was used.

- The methodology to calculate actuarial value and equivalence should also be specified in the analysis. The following factors should be considered in the methodology:
  - The methodology should use a standard set of prices or reimbursement rates for the different plans. In other words, the differences between the prices paid between the plans should not be considered as a source of difference in actuarial value between the plans.
  - The methodology should consider differences between the cost sharing requirements of the plans. The actuarial value should be based on the

value of the benefits paid by the plan rather than on the value of the allowed benefits of the plans.
    - The methodology should also consider other relevant differences between the plans. This should include differences in values that result from benefits offered in the demonstration plan and not in the benchmark plans and vice versa (benefits offered in the benchmark plans but not in the demonstration plan).

- When determining whether the demonstration plan, as in effect on December 1, 2009, and the benchmark plans are actuarially equivalent, we consider a plan that has an actuarial value equal to another plan's value plus or minus 2 percent to be actuarially equivalent. This standard, which we are adopting for benchmark equivalence comparisons for purposes of assigning the newly eligible FMAP only, is based on and consistent with the November 26, 2012 proposed rule "Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation." The Center for Consumer Information and Insurance Oversight proposes to apply this +/- 2 percent *de minimis* standard to determine whether plans that will be offered on Affordable Insurance Exchanges are actuarially equivalent. Because measuring the actuarial value of plans may not be precise, particularly in cases where there are significant differences in the benefits and plan design between the demonstration plan and the benchmark plans, it is reasonable to allow for a range around the actuarial values of the plan rather than require a precise equality.

In communicating the results of this analysis, you should submit a report certified by an actuary (as described above) that contains at a minimum the following information:

- The data used in the analysis;
- The methodology used in the analysis;
- The actuarial values of the demonstration plan and the benchmark plans, and;
- An analysis of the differences in actuarial values of the demonstration plan and the benchmark plans if the demonstration plan is found not to be at least actuarially equivalent to the benchmark plans. This analysis should discuss the main reasons for the differences (for example, differences in services covered; differences in cost sharing and plan design; other key differences between the plans) as well as the relative contribution of the major differences between the plans.

Finally, as noted above, for demonstrations that have separate populations and benefit plans, an analysis should be provided for each population or plan. These analyses may be presented within the same report or in separate reports.

Section II – Benefit Assessment to Substantiate Expansion State FMAP

If, after completing the newly eligible benefit assessment described above, you determine that full benefits, benchmark benefits, or benchmark equivalent benefits were provided, and that the newly eligible FMAP is therefore not available for some or all demonstration

populations, you should answer the following questions in order to substantiate possible eligibility for the expansion state FMAP, if applicable.

In answering the questions below, please cite the applicable STC or state-based policy.

1. Did Indiana provide coverage to parents and childless adults up to at least 100 percent of poverty, as of March 23, 2010?

   If Indiana did provide coverage, please answer questions (a) through (c) below:

   a. What was the upper income level of coverage for parents as of March 23, 2010? How many people received such coverage?

   b. What was the upper income level for coverage of childless adults as of March 23, 2010? How many people received such coverage?

   c. If coverage was provided through a section 1115 demonstration, please provide the demonstration's name and project number; if through a state-only program, please identify the state-only program.

2. Was this coverage offered on a statewide basis?

3. What was the scope of coverage provided to these populations?

   a. Did the coverage include inpatient hospital services?

   b. Was the coverage dependent on access to employer coverage, employer contribution, or employment?

   c. Was the coverage limited to premium assistance, hospital-only benefits, a high deductible health plan, or a health opportunity account?

Appendix B

Indiana Medicaid

FEHB Plan - Standard Option
$300 Deductible / 15% Coinsurance

Net Medical Cost

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Allowed Average Charge	(3) Per Member Per Month Claim Cost	(4) Per Member Per Month Cost Sharing Value	(5) Net Per Member Per Month Claim Cost	
Inpatient Facility								
Medical	22.3 Admits	4.10	91.4 days	$1,686.65	$12.85	$0.37	$12.48	
Surgical	18.6 Admits	4.23	78.7 days	3,746.96	24.58	0.31	24.27	
Psychiatric/Alcohol & Drug Abuse	5.1 Admits	15.58	79.5 days	271.85	1.80	0.09	1.71	
Maternity	19.4 Admits	2.77	53.7 days	1,422.64	6.36	0.00	6.36	
Skilled Nursing Facility	1.3 Admits	21.25	27.6 days	217.57	0.50	0.00	0.50	
	66.7 Admits	4.96	330.9 days		$46.09	$0.77	$45.32	
Outpatient Facility								
Emergency Room			209 cases	$682.75	$11.89	$1.19	$10.70	
Surgery			142 cases	1,934.79	22.90	3.43	19.47	
Radiology/Pathalogy/Lab			694 cases	203.70	11.78	1.76	10.02	
Psychiatric/Alcohol & Drug Abuse			63 cases	79.30	0.41	0.06	0.35	
Preventive			329 cases	54.83	1.50	0.23	1.27	
Other Outpatient Facility			582 cases	241.40	11.70	1.85	9.85	
					$60.18	$8.52	$51.66	
Professional								
Surgery			746 proced	$360.78	$22.43	$3.36	$19.07	
Maternity			50.0 proced	784.51	3.26	0.00	3.26	
Office/Home/Urgent Care Visits			2,693 visits	44.31	9.95	4.42	5.53	
Miscellaneous Medical			1,642 proced	51.98	7.12	1.19	5.93	
Preventive			1,394 proced	32.04	3.72	2.32	1.40	
Consults			862 visits	90.63	6.50	0.85	5.65	
Vision			0 visits	0.00	0.00	0.00	0.00	
Physical Therapy			723 visits	44.00	2.65	1.21	1.44	
Hearing and Speech Exams			21 visits	51.35	0.09	0.01	0.08	
Radiology/Pathalogy/Lab			4,832 proced	43.60	17.56	2.64	14.92	
Chiropractor			564 visits	19.82	0.93	0.93	0.00	
Outpatient Psychiatric/Alcohol & Drug Abuse			618 visits	42.68	2.20	1.03	1.17	
					$76.41	$17.96	$58.45	
Other								
Prescription Drugs			12,122 scripts	$90.84	$91.76	$16.51	$75.25	
Private Duty Nursing/Home Health			43 visits	175.90	0.63	0.09	0.54	
Ambulance			22 cases	737.04	1.35	0.14	1.21	
DME/Supplies/Prosthetics			370 proced	91.92	2.84	0.42	2.42	
Glasses/Contacts			10 cases	135.60	0.11	0.02	0.09	
Dental Benefits			133 cases	104.07	1.15	0.86	0.29	
Other - Total					$97.84	$18.04	$79.80	
Total Medical Cost					$280.52	$45.29	$235.23	
Starting Net PMPM Claim Cost for Services Subj to Ded.							$100.03	
Value of $300 Deductible							(9.87)	
Value of $4,700 Out-of-Pocket Maximum after deductible							8.02	
Value of $9,999,999 Annual Maximum							0.00	
Adjusted Net PMPM for Services Subject to Deductible							$98.18	
PMPM for Services Not Subject to Deductible							$135.20	
Total Medical Cost After Deductible and Coinsurance							$233.38	83.2%
				Prescription Drugs		$75.25	$91.76	82.0%
				Mental Health Services		3.23	4.41	73.2%
				Vision		0.09	0.11	81.8%
				Hearing		0.08	0.09	88.9%

Indiana Medicaid

State Employee PPO
$500 Deductible / 20% Coinsurance

Net Medical Cost

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Allowed Average Charge	(3) Per Member Per Month Claim Cost	(4) Per Member Per Month Cost Sharing Value	(5) Net Per Member Per Month Claim Cost	
Inpatient Facility								
Medical	22.3 Admits	4.10	91.4 days	$1,686.65	$12.85	$0.93	$11.92	
Surgical	18.6 Admits	4.23	78.7 days	3,746.96	24.58	0.78	23.80	
Psychiatric/Alcohol & Drug Abuse	5.1 Admits	15.58	79.5 days	271.85	1.80	0.22	1.58	
Maternity	19.4 Admits	2.77	53.7 days	1,422.64	6.36	0.81	5.55	
Skilled Nursing Facility	1.3 Admits	21.25	27.6 days	217.57	0.50	0.05	0.45	
	66.7 Admits	4.96	330.9 days		$46.09	$2.79	$43.30	
Outpatient Facility								
Emergency Room			209 cases	$682.75	$11.89	$1.31	$10.58	
Surgery			142 cases	1,934.79	22.90	2.96	19.94	
Radiology/Pathalogy/Lab			694 cases	203.70	11.78	2.35	9.43	
Psychiatric/Alcohol & Drug Abuse			63 cases	79.30	0.41	0.09	0.32	
Preventive			329 cases	54.83	1.50	0.30	1.20	
Other Outpatient Facility			582 cases	241.40	11.70	2.34	9.36	
					$60.18	$9.35	$50.83	
Professional								
Surgery			746 proced	$360.78	$22.43	$4.49	$17.94	
Maternity			50.0 proced	784.51	3.26	0.65	2.61	
Office/Home/Urgent Care Visits			2,693 visits	44.31	9.95	4.57	5.38	
Miscellaneous Medical			1,642 proced	51.98	7.12	1.43	5.69	
Preventive			1,394 proced	32.04	3.72	0.74	2.98	
Consults			862 visits	90.63	6.50	0.83	5.67	
Vision			0 visits	0.00	0.00	0.00	0.00	
Physical Therapy			723 visits	44.00	2.65	0.53	2.12	
Hearing and Speech Exams			21 visits	51.35	0.09	0.02	0.07	
Radiology/Pathalogy/Lab			4,832 proced	43.60	17.56	3.52	14.04	
Chiropractor			564 visits	19.82	0.93	0.19	0.74	
Outpatient Psychiatric/Alcohol & Drug Abuse			618 visits	42.68	2.20	0.44	1.76	
					$76.41	$17.41	$59.00	
Other								
Prescription Drugs			12,122 scripts	$90.84	$91.76	$6.37	$85.39	
Private Duty Nursing/Home Health			43 visits	175.90	0.63	0.07	0.56	
Ambulance			22 cases	737.04	1.35	0.09	1.26	
DME/Supplies/Prosthetics			370 proced	91.92	2.84	0.57	2.27	
Glasses/Contacts			10 cases	135.60	0.11	0.02	0.09	
Dental Benefits			133 cases	104.07	1.15	0.31	0.84	
Other - Total					$97.84	$7.43	$90.41	
Total Medical Cost					$280.52	$36.98	$243.54	
Starting Net PMPM Claim Cost for Services Subj to Ded.							$73.66	
Value of $500 Deductible							(12.15)	
Value of $1,500 Out-of-Pocket Maximum after deductible							10.72	
Value of $2,000,000 Annual Maximum							0.00	
Adjusted Net PMPM for Services Subject to Deductible							$72.23	
PMPM for Services Not Subject to Deductible							$169.88	
Total Medical Cost After Deductible and Coinsurance							$242.11	86.3%
				Prescription Drugs		$85.39	$91.76	93.1%
				Mental Health Services		3.66	4.41	83.0%
				Vision		0.09	0.11	81.8%
				Hearing		0.07	0.09	77.8%

Company Name

Advantage HMO
$250 Deductible / 50% Coinsurance

Net Medical Cost

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Allowed Average Charge	(3) Per Member Per Month Claim Cost	(4) Per Member Per Month Cost Sharing Value	(5) Net Per Member Per Month Claim Cost	
Inpatient Facility								
Medical	22.3 Admits	4.10	91.4 days	$1,686.65	$12.85	$0.46	$12.39	
Surgical	18.6 Admits	4.23	78.7 days	3,746.96	24.58	0.39	24.19	
Psychiatric/Alcohol & Drug Abuse	5.1 Admits	15.58	79.5 days	271.85	1.80	0.11	1.69	
Maternity	19.4 Admits	2.77	53.7 days	1,422.64	6.36	0.40	5.96	
Skilled Nursing Facility	1.3 Admits	21.25	27.6 days	217.57	0.50	0.00	0.50	
	66.7 Admits	4.96	330.9 days		$46.09	$1.36	$44.73	
Outpatient Facility								
Emergency Room			209 cases	$682.75	$11.89	$2.18	$9.71	
Surgery			142 cases	1,934.79	22.90	1.48	21.42	
Radiology/Pathalogy/Lab			694 cases	203.70	11.78	0.28	11.50	
Psychiatric/Alcohol & Drug Abuse			63 cases	79.30	0.41	0.18	0.23	
Preventive			329 cases	54.83	1.50	0.00	1.50	
Other Outpatient Facility			582 cases	241.40	11.70	1.35	10.35	
					$60.18	$5.47	$54.71	
Professional								
Surgery			746 proced	$360.78	$22.43	$0.00	$22.43	
Maternity			50.0 proced	784.51	3.26	0.04	3.22	
Office/Home/Urgent Care Visits			2,693 visits	44.31	9.95	5.81	4.14	
Miscellaneous Medical			1,642 proced	51.98	7.12	1.07	6.05	
Preventive			1,394 proced	32.04	3.72	0.00	3.72	
Consults			862 visits	90.63	6.50	0.35	6.15	
Vision			0 visits	0.00	0.00	0.00	0.00	
Physical Therapy			723 visits	44.00	2.65	2.11	0.54	
Hearing and Speech Exams			21 visits	51.35	0.09	0.00	0.09	
Radiology/Pathalogy/Lab			4,832 proced	43.60	17.56	0.00	17.56	
Chiropractor			564 visits	19.82	0.93	0.93	0.00	
Outpatient Psychiatric/Alcohol & Drug Abuse			618 visits	42.68	2.20	1.72	0.48	
					$76.41	$12.03	$64.38	
Other								
Prescription Drugs			12,122 scripts	$90.84	$91.76	$16.90	$74.86	
Private Duty Nursing/Home Health			43 visits	175.90	0.63	0.00	0.63	
Ambulance			22 cases	737.04	1.35	0.27	1.08	
DME/Supplies/Prosthetics			370 proced	91.92	2.84	1.42	1.42	
Glasses/Contacts			10 cases	135.60	0.11	0.02	0.09	
Dental Benefits			133 cases	104.07	1.15	0.39	0.76	
Other - Total					$97.84	$19.00	$78.84	
Total Medical Cost					$280.52	$37.86	$242.66	
Starting Net PMPM Claim Cost for Services Subj to Ded.							$28.94	
Value of $250 Deductible							(8.69)	
Value of $0 Out-of-Pocket Maximum after deductible							0.00	
Value of $9,999,999 Annual Maximum							0.00	
Adjusted Net PMPM for Services Subject to Deductible							$20.25	
PMPM for Services Not Subject to Deductible							$213.72	
Total Medical Cost After Deductible and Coinsurance							$233.97	83.4%
				Prescription Drugs		$74.86	$91.76	81.6%
				Mental Health Services		2.40	4.41	54.4%
				Vision		0.09	0.11	81.8%
				Hearing		0.09	0.09	100.0%

Indiana Medicaid

Healthy Indiana Plan Demonstration

Net Medical Cost

Benefit	Admissions Per 1,000	Length of Stay	(1) Utilization Per 1,000	(2) Allowed Average Charge	(3) Per Member Per Month Claim Cost	(4) Per Member Per Month Cost Sharing Value	(5) Net Per Member Per Month Claim Cost	
Inpatient Facility								
Medical	22.3 Admits	4.10	91.4 days	$1,686.65	$12.85	$0.00	$12.85	
Surgical	18.6 Admits	4.23	78.7 days	3,746.96	24.58	0.00	24.58	
Psychiatric/Alcohol & Drug Abuse	5.1 Admits	15.58	79.5 days	271.85	1.80	0.00	1.80	
Maternity	19.4 Admits	2.77	53.7 days	1,422.64	6.36	6.36	0.00	
Skilled Nursing Facility	1.3 Admits	21.25	27.6 days	217.57	0.50	0.00	0.50	
	66.7 Admits	4.96	330.9 days		$46.09	$6.36	$39.73	
Outpatient Facility								
Emergency Room			209 cases	$682.75	$11.89	$0.05	$11.84	
Surgery			142 cases	1,934.79	22.90	0.00	22.90	
Radiology/Pathalogy/Lab			694 cases	203.70	11.78	0.00	11.78	
Psychiatric/Alcohol & Drug Abuse			63 cases	79.30	0.41	0.00	0.41	
Preventive			329 cases	54.83	1.50	0.00	1.50	
Other Outpatient Facility			582 cases	241.40	11.70	0.00	11.70	
					$60.18	$0.05	$60.13	
Professional								
Surgery			746 proced	$360.78	$22.43	$0.00	$22.43	
Maternity			50 proced	784.51	3.26	3.26	0.00	
Office/Home/Urgent Care Visits			2,693 visits	44.31	9.95	0.00	9.95	
Miscellaneous Medical			1,642 proced	51.98	7.12	0.00	7.12	
Preventive			1,394 proced	32.04	3.72	0.00	3.72	
Consults			862 visits	90.63	6.50	0.00	6.50	
Vision			0 visits	0.00	0.00	0.00	0.00	
Physical Therapy			723 visits	44.00	2.65	0.00	2.65	
Hearing and Speech Exams			21 visits	51.35	0.09	0.00	0.09	
Radiology/Pathalogy/Lab			4,832 proced	43.60	17.56	0.00	17.56	
Chiropractor			564 visits	19.82	0.93	0.93	0.00	
Outpatient Psychiatric/Alcohol & Drug Abuse			618 visits	42.68	2.20	0.00	2.20	
					$76.41	$4.19	$72.22	
Other								
Prescription Drugs			12,122 scripts	$90.84	$91.76	$0.00	$91.76	
Private Duty Nursing/Home Health			43 visits	175.90	0.63	0.00	0.63	
Ambulance			22 cases	737.04	1.35	0.00	1.35	
DME/Supplies/Prosthetics			370 proced	91.92	2.84	0.00	2.84	
Glasses/Contacts			10 cases	135.60	0.11	0.11	0.00	
Dental Benefits			133 cases	104.07	1.15	1.15	0.00	
Other - Total					$97.84	$1.26	$96.58	
Total Medical Cost					$280.52	$11.86	$268.66	
Starting Net PMPM Claim Cost for Services Subj to Ded.							$264.60	
Value of $1,100 Deductible							(55.26)	
Value of $0 Out-of-Pocket Maximum after deductible							0.00	
Value of $300,000 Annual Maximum							(2.61)	
Adjusted Net PMPM for Services Subject to Deductible							$206.73	
PMPM for Services Not Subject to Deductible							$4.06	
Total Medical Cost After Deductible and Coinsurance							$210.79	75.1%
				Prescription Drugs		$91.76	$91.76	100.0%
				Mental Health Services		4.41	4.41	100.0%
				Vision		0.00	0.11	0.0%
				Hearing		0.09	0.09	100.0%

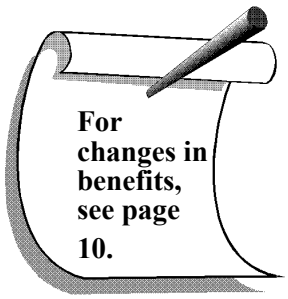
Appendix C

Blue Cross® and Blue Shield® Service Benefit Plan

http://www.fepblue.org

2009

A fee-for-service plan (standard and basic option) with a preferred provider organization



Sponsored and administered by: The Blue Cross and Blue Shield Association and participating Blue Cross and Blue Shield Plans

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the FEHB

Enrollment codes for this Plan:

104 Standard Option - Self Only
105 Standard Option - Self and Family
111 Basic Option - Self Only
112 Basic Option - Self and Family

URAC ACCREDITED HEALTH WEB SITE

URAC ACCREDITED CASE MANAGEMENT

This Plan has Health Web Site and Case Management accreditation from URAC. See the 2009 FEHB Guide for more information on accreditation.

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Center for Retirement and Insurance Services
http://www.opm.gov/insure

RI 71-005

Important Notice from the Blue Cross and Blue Shield Service Benefit Plan About

Our Prescription Drug Coverage and Medicare

OPM has determined that the Blue Cross and Blue Shield Service Benefit Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan** under our contract (CS 1039) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan on behalf of the Blue Cross and Blue Shield Association (the Carrier). The address for the Blue Cross and Blue Shield Service Benefit Plan administrative office is:

Blue Cross and Blue Shield Service Benefit Plan
1310 G Street, NW, Suite 900
Washington, DC 20005

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health care benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on pages 9 and 10. Rates are shown on the back cover of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means the Blue Cross and Blue Shield Service Benefit Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things you can do to prevent fraud:

Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.

- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.

- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 1-800-FEP-8440 (1-800-337-8440) and explain the situation.

If we do not resolve the issue:

CALL – THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:

Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

Your child over age 22 (unless he/she is disabled and incapable of self support).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.

- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - Exactly what will you be doing?
  - About how long will it take?
  - What will happen after surgery
  - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

Ø www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

Ø www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

Ø www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

Ø www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Ø www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this fee-for-service Plan

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

General features of our Standard and Basic Options

We have a Preferred Provider Organization (PPO)

Our fee-for-service plan offers services through a PPO. This means that certain hospitals and other health care providers are "Preferred providers." When you use our PPO (Preferred) providers, you will receive covered services at a reduced cost. Your Local Plan (or, for retail pharmacies, Caremark) is solely responsible for the selection of PPO providers in your area. Contact your Local Plan for the names of PPO (Preferred) providers and to verify their continued participation. You can also go to our Web page, www.fepblue.org, which you can reach through the FEHB Web site, www.opm.gov/insure. Contact your Local Plan to request a PPO directory.

Under Standard Option, PPO (Preferred) benefits apply only when you use a PPO (Preferred) provider. PPO networks may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas. If no PPO (Preferred) provider is available, or you do not use a PPO (Preferred) provider, non-PPO (Non-preferred) benefits apply.

Under Basic Option, you must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

How we pay professional and facility providers

We pay benefits when we receive a claim for covered services. Each Local Plan contracts with hospitals and other health care facilities, physicians, and other health care professionals in its service area, and is responsible for processing and paying claims for services you receive within that area. Many, but not all, of these contracted providers are in our PPO (Preferred) network.

- **PPO providers.** PPO (Preferred) providers have agreed to accept a specific negotiated amount as payment in full for covered services provided to you. We refer to PPO facility and professional providers as "Preferred." They will generally bill the Local Plan directly, who will then pay them directly. You do not file a claim. Your out-of-pocket costs are generally less when you receive covered services from Preferred providers, and are limited to your coinsurance or copayments (and, under Standard Option only, the applicable deductible).
- **Participating providers.** Some Local Plans also contract with other providers that are not in our Preferred network. If they are professionals, we refer to them as "Participating" providers. If they are facilities, we refer to them as "Member" facilities. They have agreed to accept a different negotiated amount than our Preferred providers as payment in full. They will also generally file your claims for you. They have agreed not to bill you for more than your applicable deductible, and coinsurance or copayments, for covered services. We pay them directly, but at our Non-preferred benefit levels. Your out-of-pocket costs will be greater than if you use Preferred providers.

Note: Not all areas have Participating providers and/or Member facilities. To verify the status of a provider, please contact the Local Plan where the services will be performed.

- **Non-participating providers.** Providers who are not Preferred or Participating providers do not have contracts with us, and may or may not accept our allowance. **We refer to them as "Non-participating providers" generally, although if they are facilities we refer to them as "Non-member facilities."** When you use Non-participating providers, you may have to file your claims with us. We will then pay our benefits to you, and you must pay the provider.

You must pay any difference between the amount Non-participating providers charge and our allowance (except in certain circumstances – see page 124). In addition, you must pay any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for noncovered services. **Important: Under Standard Option, your out-of-pocket costs may be substantially higher when you use Non-participating providers than when you use Preferred or Participating providers.** Under Basic Option, you must use Preferred providers to receive benefits. See page 14 for the exceptions to this requirement.

Note: In Local Plan areas, Preferred providers and Participating providers who contract with us will accept 100% of the Plan allowance as payment in full for covered services. As a result, you are only responsible for applicable coinsurance or copayments (and, under **Standard Option** only, the applicable deductible), for covered services, and any charges for noncovered services.

General features of our High Deductible Health Plan (HDHP)

The Blue Cross and Blue Shield Service Benefit Plan Basic Option includes a sub-option called Basic Consumer Option. This High Deductible Health Plan (HDHP) is available to members who reside in Ohio; Minnesota; Tennessee; the counties of Johnson and Wyandotte in Kansas; and, in the following counties of Missouri: Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Clair, Saline, Vernon, and Worth. As with other FEHB HDHPs, our Basic Consumer Option features a calendar year deductible and an annual out-of-pocket maximum limit that are higher than other types of FEHB plans. Also, as with other FEHB Program HDHPs, our Basic Consumer Option also offers tax-favored Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs). Please see below for more information about these savings features. For detailed information about the Basic Consumer Option, please refer to the *Addendum Summarizing the Basic Consumer Option Program*.

Preventive care services

Under Basic Consumer Option, preventive care services performed by Preferred providers are paid as first dollar coverage, i. e., you pay nothing for covered services. You must use Preferred providers in order to receive benefits. See page 14 of the Service Benefit Plan brochure for the exceptions to this requirement.

Annual deductible

You must meet the Basic Consumer Option calendar year deductible before we provide benefits for non-preventive medical care. The annual deductible is $2,900 for Self Only coverage and $5,800 for Self and Family coverage.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), are not enrolled in Medicare, have not received VA benefits within the last three months, are not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by an HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- You cannot make contributions to an HRA.
- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket maximum amount for covered services is the same as your annual deductible amount: $2,900 for Self Only coverage and $5,800 for Self and Family coverage. Therefore, if you have met your annual deductible, you have also satisfied your annual maximum for out-of-pocket expenses. Your care must be provided by Preferred providers (and Non-preferred providers that meet the exception situations listed in this brochure).

Health education resources and accounts management tools

You can find information about Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs) on our Web site at www.fepblue.org. You can also access your HSA or HRA account balance in addition to your complete claims reimbursement payment history from Blue Healthcare Bank through our Web site. Blue Health Connection offers health advice and counseling in addition to information on general health topics, health care news, specific diseases, first aid, drug/medication interactions, children's health, and patient safety. You may contact Blue Health Connection by calling 1-888-258-3432 toll-free, or accessing our Web site, www.fepblue.org.

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Care management, including medical practice guidelines;
- Disease management programs; and
- How we determine if procedures are experimental or investigational.

If you want more information about us, call or write to us. Our telephone number and address are shown on the back of your Service Benefit Plan ID card. You may also visit our Web site at www.fepblue.org.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Section 2. How we change for 2009

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 (Benefits). Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- In Section 3, under **Covered professional providers**, Illinois has been added to the list of medically underserved areas for 2009. (See page 12.)

Changes to this Plan

Changes to our Standard Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. (See page 134.)
- Your $10 copayment for generic drugs purchased through the Mail Service Prescription Drug Program is now waived for the first 4 generic prescriptions filled (and/or refills ordered) per calendar year. (See page 92.)
- Your coinsurance amount for generic drugs purchased at Preferred Retail Pharmacies is now 20% of the Plan allowance. In addition, your coinsurance amount for brand-name drugs is now 30% of the Plan allowance. Previously, you paid 25% of the Plan allowance for generic drugs and 25% of the Plan allowance for brand-name drugs. (See page 91.)
- We clarified that Prescription Drug Benefits are available for diabetic test strips. (See page 90.)
- Your copayment for brand-name drugs purchased through the Mail Service Prescription Drug Program is now $65 per prescription for the first 30 brand-name prescriptions filled (and/or refills ordered) per calendar year and $50 per brand-name prescription/refill thereafter. Previously, your copayment was $35 per brand-name prescription. (See page 92.)
- The catastrophic out-of-pocket maximum for deductibles, coinsurance, and copayments is now $5,000 per year when you use Preferred providers and $7,000 per year when you use a combination of Preferred and Non-preferred providers. Previously, the out-of-pocket maximum was $4,500 for Preferred provider services and $6,500 for both Preferred and Non-preferred provider services. (See page 21.)
- You now pay 15% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, pathologists, and assistant surgeons (including assistant surgeons in a physician's office). You are also responsible for any difference between our allowance and the billed amount. Previously, you paid 10% of the Plan allowance. (See pages 28 and 51.)
- Your copayment for office visits to Preferred providers is now $20 per visit. Previously, you paid $15 per visit. [See Sections 5(a), 5(d), and 5(e).]
- Your coinsurance amount for office visits to Non-preferred providers is now 30% of the Plan allowance. Previously, you paid 25% of the Plan allowance. [See Sections 5(a), 5(d), and 5(e).]
- Your coinsurance amount for certain Preferred professional services is now 15% of the Plan allowance. In addition, your coinsurance amount for certain Non-preferred professional services is now 30% of the Plan allowance. Previously, you paid 10% of the Plan allowance for Preferred provider services and 25% of the Plan allowance for Non-preferred provider services. [See Sections 5(a), 5(b), 5(d), and 5(e).]
- You may now receive specific benefit information in advance about non-emergency surgeries to be performed by Non-participating physicians when the charge for the surgery will be $5,000 or more. (See page 17.)
- You now pay 100% of the billed amount up to a maximum of $800 for anesthesia provided by a Non-participating anesthesiologist or certified registered nurse anesthetist (CRNA). Previously, you paid 25% of the Plan allowance, plus any difference between our allowance and the billed amount. [See Section 5(b).]
- Your copayment for inpatient care at Preferred hospitals is now $200 per admission. Previously, you paid $100 per admission. [See Sections 5(c) and 5(e).]
- Your copayment for ambulance transport related to a medical emergency is now $100 per day for ground ambulance transport and $150 per day for air or sea ambulance transport. Previously, you paid $50 per day for these types of services. [See Section 5(d).]

- You now pay 100% of the billed amount up to a maximum of $350 per visit for professional care provided in an emergency room by a Non-participating emergency room physician. Previously, you paid any difference between the Plan allowance and the billed amount for care related to an accidental injury, and 25% of the Plan allowance, plus any difference between our allowance and the billed amount for care related to a medical emergency. [See Section 5(d).]
- You must now obtain prior approval before receiving any outpatient Mental Health/Substance Abuse services. We no longer require a treatment plan from your provider prior to your ninth outpatient Mental Health/Substance Abuse visit. (See pages 16 and 84.)

Changes to our Basic Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. (See page 134.)
- Your copayment for office visits to Preferred primary care professionals is now $25 per visit. Previously, you paid $20 per visit. [See Sections 5(a), 5(d), and 5(e).]
- Your copayment for outpatient facility care at Preferred hospitals is now $50 per day per facility. Previously, you paid $40 per day. [See Sections 5(c) and 5(e).]
- Your copayment for emergency room care related to an accidental injury or medical emergency is now $75 per visit. Previously, your copayment was $50 per visit. [See Section 5(d).]
- Your copayment for ambulance transport related to a medical emergency or accidental injury is now $100 per day for ground ambulance transport and $150 per day for air or sea ambulance transport. Previously, you paid $50 per day for these types of services. [See Section 5(d).]
- Your copayment for Level II formulary or preferred brand-name drugs purchased at a Preferred Retail Pharmacy is now $35 per prescription. In addition, the minimum amount you pay for Level III non-formulary or non-preferred brand-name drugs is now $45 for each 34-day supply, or $135 for a 90-day supply. Previously, you paid $30 for Level II prescriptions, and for Level III prescriptions, you paid a minimum of $35 for each purchase of a 34-day supply, or $105 for a 90-day supply. (See page 91.)

Changes to both our Standard and Basic Options

- We now provide benefits for set-up of portable X-ray equipment. Previously, benefits were not available for this service. (See page 31.)
- We now provide Preventive Care Benefits (Adult) for screening and behavioral change interventions for tobacco use and alcohol/substance abuse. Previously, Preventive Care Benefits were not available for these services. (See page 32.)
- We now provide benefits for the nonsurgical treatment of amblyopia and strabismus for children from birth through age 18. Previously, we provided benefits through age 12. (See page 42.)
- We now provide benefits for hearing aids for adults, limited to $1,000 per ear per 36-month period subject to the member cost-sharing amounts shown on page 43. Previously, benefits for adults were limited to bone anchored hearing aids.
- We now provide benefits for wigs (scalp hair prosthesis) due to hair loss due to chemotherapy for the treatment of cancer, limited to a maximum of $350 for one wig per lifetime. Previously, benefits were not available for these types of wigs. (See page 44.)
- We now provide benefits for medical foods that are administered orally and that provide the sole source (100%) of nutrition for children up to age 22, for up to one year following the date of the initial prescription or physician order for the medical food. Previously, benefits were not available for these types of products. (See page 47.)
- We now provide benefits for additional types of stem cell transplants. [See Section 5(b).]
- We now provide Prescription Drug Benefits for one influenza vaccine each flu season provided by a Preferred retail pharmacy. Previously, Prescription Drug Benefits were not available for these types of vaccines. (See page 90.)
- Certain Preferred facilities have now been selected to be Blue Distinction Centers for Complex and Rare Cancers℠. More information about these centers appears on page 13.
- Chiropractors/Doctors of Chiropractic (D.C.) are now considered “other covered health care professionals.” Previously, these types of providers were listed as physicians. (See page 11.)

- You must now obtain prior approval for outpatient surgery for morbid obesity, outpatient surgical correction of congenital anomalies, and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Previously, these types of services did not require prior approval. (See page 16.)
- We clarified that benefits are not available for online medical evaluation and management services. (See page 31.)
- We clarified that we do not provide benefits for preventive medicine counseling and/or risk factor reduction intervention, interpretation of health risk assessments, or self-administered health risk assessments. (See page 32.)
- We clarified that benefits are not available for services provided by massage therapists. (See page 40.)
- We clarified that benefits are not available for orthodontic care, except for orthodontia associated with surgery to correct accidental injuries. (See page 55.)
- We clarified that benefits are not available for physician charges for shift differentials. (See page 107.)
- We clarified that benefits are not available for services performed or billed by residential therapeutic camps or for light boxes. (See pages 83 and 87.)
- We clarified the types of professional providers covered for Mental Health and Substance Abuse Care. (See pages 82 and 85.)
- We clarified that we may request medical records to support your claim for services received overseas. (See page 104.)
- We clarified that World Access Service Corporation is now Mondial Assistance. (See page 104.)

Section 3. How you receive benefits

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You will need it whenever you receive services from a covered provider, or fill a prescription through a Preferred retail or internet pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call the Local Plan serving the area where you reside and ask them to assist you, or write to us directly at: FEP Enrollment Services, 840 First Street, NE, Washington, DC 20065. You may also request replacement cards through our Web site, www.fepblue.org.

Where you get covered care

Under Standard Option, you can get care from any "covered professional provider" or "covered facility provider." How much we pay – and you pay – depends on the type of covered provider you use. If you use our Preferred, Participating, or Member providers, you will pay less.

Under Basic Option, you **must** use those "covered professional providers" or "covered facility providers" that are **Preferred providers** for Basic Option in order to receive benefits. Please refer to page 14 for the exceptions to this requirement. Refer to page 6 for more information about Preferred providers.

For Basic Option, the term "primary care provider" includes family practitioners, general practitioners, medical internists, pediatricians, obstetricians/gynecologists, and physician assistants.

- **Covered professional providers**

We consider the following to be covered professionals when they perform services within the scope of their license or certification:

Physicians – Doctors of medicine (M.D.); osteopathy (D.O.); dental surgery (D.D.S.); medical dentistry (D.M.D.); podiatric medicine (D.P.M.); and optometry (O.D.).

Other Covered Health Care Professionals – Professionals who provide additional covered services and meet the state's applicable licensing or certification requirements and the requirements of the Local Plan. Examples of other covered health care professionals include:

- **Audiologist –** A professional who, if the state requires it, is licensed, certified, or registered as an audiologist where the services are performed.
- **Chiropractor/Doctor of Chiropractic (D.C.)** – A professional who is licensed as a chiropractor by the appropriate government agency to practice chiropractic medicine where the service is performed.
- **Clinical Psychologist–** A psychologist who (1) is licensed or certified in the state where the services are performed; (2) has a doctoral degree in psychology (or an allied degree if, in the individual state, the academic licensing/certification requirement for clinical psychologist is met by an allied degree) or is approved by the Local Plan; and (3) has met the clinical psychological experience requirements of the individual State Licensing Board.
- **Clinical Social Worker–** A social worker who (1) has a master's or doctoral degree in social work; (2) has at least two years of clinical social work practice; and (3) if the state requires it, is licensed, certified, or registered as a social worker where the services are performed.
- **Diabetic Educator–** A professional who, if the state requires it, is licensed, certified, or registered as a diabetic educator where the services are performed.

- **Dietician –** A professional who, if the state requires it, is licensed, certified, or registered as a dietician where the services are performed.
- **Independent Laboratory–** A laboratory that is licensed under state law or, where no licensing requirement exists, that is approved by the Local Plan.
- **Nurse Midwife –** A person who is certified by the American College of Nurse Midwives or, if the state requires it, is licensed or certified as a nurse midwife.
- **Nurse Practitioner/Clinical Specialist –** A person who (1) has an active R.N. license in the United States; (2) has a baccalaureate or higher degree in nursing; and (3) if the state requires it, is licensed or certified as a nurse practitioner or clinical nurse specialist.
- **Nursing School Administered Clinic –** A clinic that (1) is licensed or certified in the state where services are performed; and (2) provides ambulatory care in an outpatient setting – primarily in rural or inner-city areas where there is a shortage of physicians. Services billed by these clinics are considered outpatient "office" services rather than facility charges.
- **Nutritionist –** A professional who, if the state requires it, is licensed, certified, or registered as a nutritionist where the services are performed.
- **Physical, Speech, and Occupational Therapist –** A professional who is licensed where the services are performed or meets the requirements of the Local Plan to provide physical, speech, or occupational therapy services.
- **Physician Assistant –** A person who is nationally certified by the National Commission on Certification of Physician Assistants in conjunction with the National Board of Medical Examiners or, if the state requires it, is licensed, certified, or registered as a physician assistant where the services are performed.
- **Otherprofessional providers** specifically shown in the benefit descriptions in Section 5.

Medically underserved areas. In the states OPM determines are "medically underserved":

Under Standard Option, we cover any licensed medical practitioner for any covered service performed within the scope of that license.

Under Basic Option, we cover any licensed medical practitioner who is **Preferred** for any covered service performed within the scope of that license.

For 2009, the states are: Alabama, Arizona, Idaho, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, and Wyoming.

- **Covered facility providers**

Covered facilities include those listed below, when they meet the state's applicable licensing or certification requirements.

- **Hospital** - An institution, or a distinct portion of an institution, that:

1. Primarily provides diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of injured and sick persons provided or supervised by a staff of licensed doctors of medicine (M.D.) or licensed doctors of osteopathy (D.O.), for compensation from its patients, on an inpatient or outpatient basis;
2. Continuously provides 24-hour-a-day professional registered nursing (R.N.) services; and
3. Is not, other than incidentally, an extended care facility; a nursing home; a place for rest; an institution for exceptional children, the aged, drug addicts, or alcoholics; or a custodial or domiciliary institution having as its primary purpose the furnishing of food, shelter, training, or non-medical personal services.

Note: We consider college infirmaries to be Non-member hospitals. In addition, we may, at our discretion, recognize any institution located outside the 50 states and the District of Columbia as a Non-member hospital.

- **Freestanding Ambulatory Facility–** A freestanding facility, such as an ambulatory surgical center, freestanding surgi-center, freestanding dialysis center, or freestanding ambulatory medical facility, that:

1. Provides services in an outpatient setting;
2. Contains permanent amenities and equipment primarily for the purpose of performing medical, surgical, and/or renal dialysis procedures;
3. Provides treatment performed or supervised by doctors and/or nurses, and may include other professional services performed at the facility; and
4. Is not, other than incidentally, an office or clinic for the private practice of a doctor or other professional.

Note: We may, at our discretion, recognize any other similar facilities, such as birthing centers, as freestanding ambulatory facilities.

- **Blue Distinction Centers for Bariatric Surgery, Cardiac Care, and Complex and Rare Cancers**

Certain Preferred facilities have been selected to be Blue Distinction Centers for Bariatric Surgery, Cardiac Care, and/or Complex and Rare Cancers. These facilities meet stringent quality criteria established by expert physician panels, surgeons, and other medical professionals. The Blue Distinction Centers for Bariatric Surgery℠ provide a full range of bariatric surgical care services, including inpatient care, post-operative care, follow-up care, and patient education. The Blue Distinction Centers for Cardiac Care℠ provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization (including percutaneous coronary interventions), and cardiac surgery (including coronary artery bypass graft surgery). The Blue Distinction Centers for Complex and Rare Cancers℠ offer comprehensive inpatient cancer care programs for adults, delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise in treating complex and rare types of cancer.

If you are considering covered bariatric surgery, cardiac procedures, or inpatient treatment for a complex or rare cancer, you may want to consider receiving those services at a Blue Distinction Center. You can find these facilities listed in the online provider directory available at www.fepblue.org, or by calling the customer service number listed on the back of your ID card.

- **Blue Distinction Centers for Transplants℠**

In addition to Preferred transplant facilities, you have access to the Blue Distinction Centers for Transplants℠, a centers of excellence program. Blue Distinction Centers for Transplants are selected based on their ability to meet defined clinical quality criteria that are unique for each type of transplant. These facilities negotiate a payment for transplant services performed during the transplant period (see page 125 for the definition of "transplant period").

Members who choose to use a Blue Distinction Centers for Transplants facility for a covered transplant only pay the $200 per admission copayment under Standard Option, or the $100 per day copayment ($500 maximum) under Basic Option, for the transplant period. Members are not responsible for additional costs for included professional services. Regular Preferred benefits (subject to the regular cost-sharing levels for facility and professional services) are paid for pre- and post-transplant services performed in Blue Distinction Centers for Transplants before and after the transplant period.

Blue Distinction Centers for Transplants are available for eight types of transplants: heart; heart-lung; single, double, or lobar lung; liver; pancreas; simultaneous pancreas-kidney; simultaneous liver-kidney; and autologous or allogeneic bone marrow (see page 63 for limitations).

All members (including those who have Medicare Part A or another group health insurance policy as their primary payer) must contact us at the customer service number listed on the back of their ID card before obtaining services. We will refer you to the designated Plan transplant coordinator for information about Blue Distinction Centers for Transplants and assistance in arranging for your transplant at a Blue Distinction Centers for Transplants facility.

- **Cancer Research Facility –** A facility that is:

1. A National Cooperative Cancer Study Group institution that is funded by the National Cancer Institute (NCI) and has been approved by a Cooperative Group as a blood or marrow stem cell transplant center;
2. An NCI-designated Cancer Center; or
3. An institution that has a peer-reviewed grant funded by the National Cancer Institute (NCI) or National Institutes of Health (NIH) to study allogeneic or autologous blood or marrow stem cell transplants.

- **Other facilities** specifically listed in the benefits descriptions in Section 5(c).

What you must do to get covered care

Under Standard Option, you can go you can go to any covered provider you want, but in some circumstances, we must approve your care in advance.

Under Basic Option, you **must** use **Preferred** providers in order to receive benefits, except under the special situations listed below. In addition, we must approve certain types of care in advance. Please refer to Section 4, *Your costs for covered services*, for related benefits information.

1. Medical emergency or accidental injury care in a hospital emergency room and related ambulance transport as described in Section 5(d), *Emergency services/accidents*;
2. Professional care provided at Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons;
3. Laboratory and pathology services, X-rays, and diagnostic tests billed by Non-preferred laboratories, radiologists, and outpatient facilities;
4. Services of assistant surgeons;
5. Special provider access situations (contact your Local Plan for more information); or
6. Care received outside the United States and Puerto Rico.

Unless otherwise noted in Section 5, when services of Non-preferred providers are covered in a special exception, benefits will be provided based on the Plan allowance. You are responsible for the applicable coinsurance or copayment, and may also be responsible for any difference between our allowance and the billed amount.

- **Transitional care**

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan, or
- lose access to your Preferred specialist because we terminate our contract with your specialist for reasons other than for cause,

you may be able to continue seeing your specialist and receiving any Preferred benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and your Preferred benefits will continue until the end of your postpartum care, even if it is beyond the 90 days.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call us immediately. If you have not yet received your Service Benefit Plan ID card, you can contact your Local Plan at the telephone number listed in your local telephone directory. If you already have your new Service Benefit Plan ID card, call us at the number on the back of the card. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

However, if you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

How to get approval for:

- **Your hospital stay**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay, the procedure(s)/service(s) to be performed, and the number of days required to treat your condition. Unless we are misled by the information given to us, we will not change our decision on medical necessity.

In most cases, your physician or hospital will take care of precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether they have contacted us.

Warning:

We will reduce our benefits for the inpatient hospital stay by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will not pay any benefits.

- You, your representative, your doctor, or your hospital must call us at the telephone number listed on the back of your Service Benefit Plan ID card any time prior to admission.
- If you have an **emergency admission** due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, your doctor, or your hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
  - Enrollee's name and Plan identification number;
  - Patient's name, birth date, and phone number;
  - Reason for hospitalization, proposed treatment, or surgery;
  - Name and phone number of admitting doctor;
  - Name of hospital or facility; and
  - Number of planned days of confinement.

How to precertify an admission

- We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

- **Maternity care**

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

- **If your hospital stay needs to be extended:**

If your hospital stay – including for maternity care – needs to be extended, you, your representative, your doctor, or the hospital must ask us to approve the additional days.

- **What happens when you do not follow the precertification rules**

- If no one contacts us, we will decide whether the hospital stay was medically necessary.
- If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty. [See Section 5(c) for payment information.]
- If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

If we denied the precertification request, we will not pay inpatient hospital benefits or inpatient physician care benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

When we precertified the admission but you remained in the hospital beyond the number of days we approved and you did not get the additional days precertified, then:

- for the part of the admission that was medically necessary, we will pay inpatient benefits, but
- for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and we will not pay inpatient benefits.

- **Exceptions:**

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payer for the hospital stay. (See page 13 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)
- Medicare Part A is the primary payer for the hospital stay. (See page 13 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)

Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then you **do** need precertification.

- **Other services**

These services require prior approval under both Standard and Basic Option:

- **Outpatient surgical services –** The surgical services listed below require prior approval when they are to be performed on an outpatient basis. This requirement applies to both the physician services and the facility services from Preferred, Participating/Member, and Non-participating/Non-member providers. You must contact us at the customer service number listed on the back of your ID card before obtaining these types of services.
- Outpatient surgery for morbid obesity;
- Outpatient surgical correction of congenital anomalies; and

- Outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth.
- **Home hospice care –** Contact us at the customer service number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination and advise you which home hospice care agencies we have approved. See page 73 for information about the exception to this requirement.
- **Outpatient mental health and substance abuse treatment – You must call us** at the mental health and substance abuse number listed on the back of your ID card **before receiving any outpatient professional or outpatient facility care from Preferred providers.** We will then provide you with the names and phone numbers of several Preferred providers to choose from and tell you how many visits we are initially approving. For intensive outpatient treatment and partial hospitalization from Preferred providers, we will request the medical evidence we need to make our coverage determination. We will also consider the necessary duration of either of these services.
- **Organ/tissue transplants –** Contact us at the customer service number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination. We will consider whether the facility is approved for the procedure and whether you meet the facility's criteria.
- **Clinical trials for certain organ/tissue transplants –** See pages 60 and 61 for the list of conditions covered only in clinical trials for blood or marrow stem cell transplants. Contact our Transplant Clinical Trials Information Unit at 1-800-225-2268 for information or to request prior approval before obtaining services. We will request the medical evidence we need to make our coverage determination.

Note: For the purposes of the blood or marrow stem cell clinical trial transplants listed on pages 60 and 61, a clinical trial is a research study whose protocol has been reviewed and approved by the Institutional Review Board of the Cancer Research Facility (see page 13) where the procedure is to be delivered.

- **Prescription drugs –** Certain prescription drugs require prior approval. Contact our Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077 for the hearing impaired) to request prior approval, or to obtain an updated list of prescription drugs that require prior approval. We will request the information we need to make our coverage determination. You must periodically renew prior approval for certain drugs. See page 94 for more about our prescription drug prior approval program, which is part of our Patient Safety and Quality Monitoring (PSQM) program.

Note: Benefits for drugs to aid smoking cessation that require a prescription by Federal law are limited to one course of treatment per calendar year. Prior approval is required before benefits will be provided for additional medication. To obtain approval, the physician must certify the patient is participating in a smoking cessation program that provides clinical treatment, including counseling and behavioral therapies.

Note: Until we approve them, you must pay for these drugs in full when you purchase them – even if you purchase them at a Preferred retail pharmacy or through an internet pharmacy – and submit the expense(s) to us on a claim form. Preferred pharmacies will not file these claims for you.

Under Standard Option, members may use our Mail Service Prescription Drug Program to fill their prescriptions. However, the Mail Service Prescription Drug Program also will not fill your prescription until you have obtained prior approval. Medco, the administrator of the Mail Service Prescription Drug Program, will hold your prescription for you up to thirty days. If prior approval is not obtained within 30 days, your prescription will be returned to you along with a letter explaining the prior approval procedures.

The Mail Service Prescription Drug Program is not available under **Basic Option**.

Surgery by Non-participating providers under Standard Option

You may receive specific benefit information in advance about non-emergency surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. When you contact your local Blue Cross and Blue Shield Plan before your surgery, the Local Plan will review your planned surgery to determine your coverage, the medical necessity of the procedure(s), and the Plan allowance for the services. You can call your Local Plan at the customer service number on the back of your ID card.

Note: Standard Option members are not required to obtain prior approval for surgeries performed by Non-participating providers (unless the surgery is listed on page 16 or is one of the transplant procedures listed above) – even if the charge will be $5,000 or more. If you do not call your Local Plan in advance of the surgery, we will review your claim to provide benefits for the services in accordance with the terms of your coverage.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for your covered care:

Copayment

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: If you have Standard Option when you see your Preferred physician, you pay a copayment of $20 for the office visit and we then pay the remainder of the amount we allow for the office visit. (You may have to pay separately for other services you receive while in the physician's office.) When you go into a Preferred hospital, you pay a copayment of $200 per admission. We then pay the remainder of the amount we allow for the covered services you receive.

Copayments do not apply to services and supplies that are subject to a deductible and/or coinsurance amount.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than your copayment, you pay the lower amount.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward your deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply that you then pay counts toward meeting your deductible.

Under Standard Option, the calendar year deductible is $300 per person. Under a family enrollment, the calendar year deductible for each family member is satisfied and benefits are payable for all family members when the combined covered expenses of the family reach $600.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your Standard Option calendar year deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your Standard Option calendar year deductible ($220) has been satisfied.

Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Under Basic Option, there is **no calendar year deductible**.

Coinsurance

Coinsurance is the percentage of the Plan allowance that you must pay for your care. Your coinsurance is based on the Plan allowance, or billed amount, whichever is less. **Under Standard Option only,** coinsurance does not begin until you meet your deductible.

Example: You pay 15% of the Plan allowance under Standard Option for durable medical equipment obtained from a Preferred provider, after meeting your $300 calendar year deductible.

If your provider routinely waives your cost

Note: **If your provider routinely waives** (does not require you to pay) your applicable deductible (under Standard Option only), coinsurance, or copayments, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

Example: If your physician ordinarily charges $100 for a service but routinely waives your 30% Standard Option coinsurance, the actual charge is $70. We will pay $49.00 (70% of the actual charge of $70).

Waivers

In some instances, a Preferred, Participating, or Member provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Local Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at the customer service number on the back of your ID card.

Differences between our allowance and the bill

Our **"Plan allowance"** is the amount we use to calculate our payment for certain types of covered services. Fee-for-service plans arrive at their allowances in different ways, so allowances vary. For information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the type of provider you use. In this Plan, we have the following types of providers:

- **Preferred providers.** These types of providers have agreements with the Local Plan to limit what they bill our members. Because of that, when you use a Preferred provider, your share of the provider's bill for covered care is limited.

  Under Standard Option, your share consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a Preferred physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 15% of our $100 allowance ($15). Because of the agreement, your Preferred physician will not bill you for the $50 difference between our allowance and his/her bill.

  Under Basic Option, your share consists only of your copayment or coinsurance amount, since there is no calendar year deductible. Here is an example involving a copayment: You see a Preferred physician who charges $150 for covered services subject to a $25 copayment. Even though our allowance may be $100, you still pay just the $25 copayment. Because of the agreement, your Preferred physician will not bill you for the $125 difference between your copayment and his/her bill.

  Remember, under Basic Option, you must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.

- **Participating providers.** These types of **Non-preferred providers** have agreements with the Local Plan to limit what they bill our **Standard Option** members.

  Under Standard Option, when you use a Participating provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example: You see a Participating physician who charges $150, but the Plan allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 30% of our $100 allowance ($30). Because of the agreement, your Participating physician will not bill you for the $50 difference between our allowance and his/her bill.

  Under Basic Option, there are no benefits for care performed by Participating providers; you pay all charges. See page 14 for the exceptions to this requirement.

- **Non-participating providers.** These **Non-preferred providers** have no agreement to limit what they will bill you.

Under Standard Option, when you use a Non-participating provider, you will pay your deductible and coinsurance –**plus** any difference between our allowance and the charges on the bill (except in certain circumstances – see page 124). For example, you see a Non-participating physician who charges $150. The Plan allowance is again $100, and you have met your deductible. You are responsible for your coinsurance, so you pay 30% of the $100 Plan allowance or $30. Plus, because there is no agreement between the Non-participating physician and us, the physician can bill you for the $50 difference between our allowance and his/her bill.

Under Basic Option, there are no benefits for care performed by Non-participating providers; you pay all charges. See page 14 for the exceptions to this requirement.

The following table illustrates examples of how much you have to pay out-of-pocket for services from a Preferred physician, a Participating physician, and a Non-participating physician. The table uses our example of a service for which the physician charges $150 and the Plan allowance is $100. For Standard Option, the table shows the amount you pay if you have met your calendar year deductible.

Example	Preferred Physician Standard Option	Preferred Physician Basic Option	Participating physician (Standard Option*)	Non-participating physician (Standard Option*)
Physician's charge	$150	$150	$150	$150
Our allowance	We set it at: $100	We set it at: $100	We set it at: $100	We set it at: $100
We pay	85% of our allowance: $85	Our allowance less copay: $75	70% of our allowance: $70	70% of our allowance: $70
You owe: Coinsurance	15% of our allowance: $15	Not applicable	30% of our allowance: $30	30% of our allowance: $30
You owe: Copayment	Not applicable	$25	Not applicable	Not applicable
+Difference up to charge?	No: $0	No: $0	No: $0	Yes: $50
TOTAL YOU PAY	$15	$25	$30	$80

***Under Basic Option, there are no benefits for care performed by Participating and Non-participating physicians. You must use Preferred providers in order to receive benefits.** See page 14 for the exceptions to this requirement.

Note: Under Standard Option, had you not met any of your deductible in the above examples, only our allowance ($100), which you would pay in full, would count toward your deductible.

Important notice!

Preferred hospitals may contract with Non-participating providers to provide certain medical or surgical services at their facilities. Non-participating providers have no agreements with your Local Plan to limit what they can bill you. Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive.

Here is an example: You have coverage under Standard Option and go into a Preferred hospital for surgery. During surgery, you receive the services of a Non-participating anesthesiologist. Under Standard Option, members pay the amount billed for services provided in Preferred facilities by Non-participating anesthesiologists, up to a maximum copayment amount of $800 per anesthetist per day (no deductible or coinsurance amounts apply). For Preferred provider services, members pay only a coinsurance amount of 15% of the Preferred provider allowance after meeting the $300 calendar year deductible.

In this example, the Non-participating anesthesiologist charges $1,200 for his/her services. Our Preferred provider allowance for those services is $400. For the Non-preferred anesthesiologist's services, you would be responsible for paying the full $800 copayment amount. If you instead received services from a Preferred anesthesiologist, you would pay only 15% of the $400 allowance (after meeting your deductible), or $60, resulting in a savings to you of $740 ($800 - $60 = $740).

Always request Preferred providers for your care. Call your Local Plan at the number listed on the back of your ID card or go to our Web site, www.fepblue.org, to check the contracting status of your provider or to locate a Preferred provider near you.

- **Overseas providers.** We pay overseas claims at Preferred benefit levels, using an Overseas Fee Schedule as our Plan allowance. Most overseas professional providers are under no obligation to accept our allowance, and you must pay any difference between our payment and the provider's bill. For facility care you receive overseas, we provide benefits in full after you pay the applicable copayment or coinsurance (and, under Standard Option, any deductible amount that may apply). See Section 5(i) for more information about our overseas benefits.
- **Dental care. Under Standard Option,** we pay scheduled amounts for routine dental services and you pay any balance. **Under Basic Option,** you pay $20 for any covered evaluation and we pay the balance for covered services. See Section 5(g) for a listing of covered dental services and additional payment information.
- **Hospital care.** You pay the coinsurance or copayment amounts listed in Section 5(c). **Under Standard Option,** you must meet your deductible before we begin providing benefits for certain hospital-billed services. **Under Basic Option,** you must use **Preferred** facilities in order to receive benefits. See page 14 for the exceptions to this requirement.

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

If the total amount of out-of-pocket expenses in a calendar year for you and your covered family members for deductibles (Standard Option only), coinsurance, and copayments (other than those listed below) exceeds $7,000 under Standard Option, or $5,000 under Basic Option, then you and any covered family members will not have to continue paying them for the remainder of the calendar year.

Standard Option Preferred maximum: If the total amount of these out-of-pocket expenses from using Preferred providers for you and your covered family members exceeds $5,000 in a calendar year under Standard Option, then you and any covered family members will not have to pay these expenses for the remainder of the calendar year when you continue to use Preferred providers. You will, however, have to pay them when you use Non-preferred providers, until your out-of-pocket expenses (for the services of both Preferred and Non-preferred providers) reach $7,000 under Standard Option, as shown above.

Basic Option maximum: If the total amount of these out-of-pocket expenses from using Preferred providers for you and your covered family members exceeds $5,000 in a calendar year under Basic Option, then you and any covered family members will not have to pay these expenses for the remainder of the calendar year.

The following expenses are not included under this feature. These expenses do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay them even after your expenses exceed the limits described above.

- The difference between the Plan allowance and the billed amount. See pages 19-21;
- Expenses for services, drugs, and supplies in excess of our maximum benefit limitations;
- Under Standard Option, your 30% coinsurance for inpatient care in a Non-member hospital;
- Under Standard Option, your 30% coinsurance for outpatient care by a Non-member facility;
- Under Standard Option, your $800 copayment (or the total amount you paid if less than $800) for anesthesia provided by a Non-participating anesthesiologist or certified registered nurse anesthetist (CRNA). See Section 5(b);
- Under Standard Option, your $350 per visit copayment (or the total amount you paid if less than $350) for professional care provided in an emergency room by a Non-participating emergency room physician. See Section 5(d);
- Your expenses for mental conditions and substance abuse care by a Non-preferred professional or facility provider;
- Your expenses for dental services in excess of our fee schedule payments under Standard Option. See Section 5(g);
- The $500 penalty for failing to obtain precertification, and any other amounts you pay because we reduce benefits for not complying with our cost containment requirements;
- Under Basic Option, coinsurance you pay for non-formulary brand-name drugs; and
- Under Basic Option, your expenses for care received from Participating/Non-participating professional providers or Member/Non-member facilities, except for coinsurance and copayments you pay in those special situations where we do pay for care provided by Non-preferred providers. Please see page 14 for the exceptions to the requirement to use Preferred providers.

Carryover

Note: If you change to another plan during Open Season, we will continue to provide benefits between January 1 and the effective date of your new plan.

- If you had already paid the out-of-pocket maximum, we will continue to provide benefits as described on page 21 and on this page until the effective date of your new plan.

- If you had not yet paid the out-of-pocket maximum, we will apply any expenses you incur in January (before the effective date of your new plan) to our prior year's out-of-pocket maximum. Once you reach the maximum, you do not need to pay our deductibles, copayments, or coinsurance amounts (except as shown on page 21 and on this page) from that point until the effective date of your new plan.

Note: Because benefit changes are effective January 1, we will apply our next year's benefits to any expenses you incur in January.

Note: If you change options in this Plan during the year, we will credit the amounts already accumulated toward the catastrophic protection out-of-pocket limit of your old option to the catastrophic protection out-of-pocket limit of your new option. If you change from Self Only to Self and Family, or vice versa, during the calendar year, please call us about your out-of-pocket accumulations and how they carry over.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

Note: We will generally first seek recovery from the provider if we paid the provider directly, or from the person (covered family member, guardian, custodial parent, etc.) to whom we sent our payment.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

When you are age 65 or over and do not have Medicare

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital care and non-physician based care are not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you . . .

- are age 65 or over; and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, or as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care,

- the law requires us to base our payment on an amount – the "equivalent Medicare amount" – set by Medicare's rules for what Medicare would pay, not on the actual charge;
- you are responsible for your deductible (Standard Option only), coinsurance, or copayments under this Plan;
- you are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you; and
- the law prohibits a hospital from collecting more than the equivalent Medicare amount.

And, for your physician care, the law requires us to base our payment and your applicable coinsurance or copayment on . . .

- an amount set by Medicare and called the "Medicare approved amount," or
- the actual charge if it is lower than the Medicare approved amount.

If your physician . . .	**Then you are responsible for . . .**
Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network	Standard Option: your deductibles, coinsurance, and copayments Basic Option: your copayments and coinsurance
Participates with Medicare or accepts Medicare assignment and is **not** in our Preferred network	Standard Option: your deductibles, coinsurance, and copayments, and any balance up to the Medicare approved amount Basic Option: all charges
Does not participate with Medicare, and is in our Preferred network	Standard Option: your deductibles, coinsurance, and copayments, and any balance up to 115% of the Medicare approved amount Basic Option: your copayments and coinsurance, and any balance up to 115% of the Medicare approved amount
Does not participate with Medicare and is **not** in our Preferred network	Standard Option: your deductibles, coinsurance, copayments, Basic Option: all charges

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

When you have the Original Medicare Plan (Part A, Part B, or both)

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays.

Note: We pay our regular benefits for emergency services to a facility provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the MRA statement is submitted to determine our payment for covered services provided to you if Medicare is primary, when Medicare does not pay the VA facility.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

- If your physician **accepts** Medicare assignment, then you pay nothing for covered charges (see note below for Basic Option).
- If your physician **does not accept** Medicare assignment, then you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment (see note below for Basic Option).

Note: **Under Basic Option,** you must see **Preferred** providers in order to receive benefits. See page 14 for the exceptions to this requirement.

It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) form that you receive from Medicare will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Please see Section 9, *Coordinating benefits with other coverage*, for more information about how we coordinate benefits with Medicare.

Section 5. Benefits

See pages 9 and 10 for how our benefits changed this year. Page 132 and page 133 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Standard and Basic Option Overview

This Plan offers both a Standard and Basic Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Standard and Basic Option Section 5 is divided into subsections. Please read *Important things youshould keep in mind* at the beginning of the subsections. Also read the *General exclusions* in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Standard and Basic Option benefits, contact us at the customer service telephone number on the back of your Service Benefit Plan ID card or at our Web site at www.fepblue.org.

Each option offers unique features.

- **Standard Option** When you have Standard Option, you can use both Preferred and Non-preferred providers. However, your out-of-pocket expenses are lower when you use Preferred providers and Preferred providers will submit claims to us on your behalf. Standard Option has a calendar year deductible for some services and a $20 copayment for office visits. Standard Option also features both a Preferred retail and a Preferred mail service prescription drug program.
- **Basic Option** Basic Option does not have a calendar year deductible. Most services are subject to copayments ($25 for primary care providers and $30 for specialists). Members do not need to have referrals to see specialists. You must use Preferred providers for your care to be eligible for benefits, except in certain circumstances, such as emergency care. Preferred providers will submit claims to us on your behalf. Basic Option also offers a Preferred retail pharmacy program.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible is $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- **Under Standard Option,** we provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, pathologists, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See below and page 14 for the exceptions to this requirement.**
- **Under Basic Option,** we provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
- Please refer to Section 3, *How you receive benefits*, for a list of providers we consider to be primary care providers (under Basic Option) and other health care professionals.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.
- The amounts listed in this section are for the charges billed by a physician or other health care professional for your medical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital or other outpatient facility, etc.).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Diagnostic and treatment services	**Standard Option**	**Basic Option**
Professional services of physicians and other health care professionals: • Outpatient consultations • Outpatient second surgical opinions • Office visits • Home visits • Initial examination of a newborn needing definitive treatment when covered under a family enrollment • Pharmacotherapy [see Section 5(f) for prescription drug coverage] • Neurological testing ***Note:*** Please refer to page 31 for our coverage of laboratory, X-ray, and other diagnostic tests billed for by a physician, and to page 69 for our coverage of these services when billed for by a facility, such as the outpatient department of a hospital.	Preferred: $20 copayment for the office visit charge (No deductible) Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
Inpatient professional services: • During a hospital stay • Services for nonsurgical procedures when ordered, provided, and billed by a physician during a covered inpatient hospital admission • Medical care by the attending physician (the physician who is primarily responsible for your care when you are hospitalized) on days we pay inpatient hospital benefits ***Note:*** A consulting physician employed by the hospital is not the attending physician. • Consultations when requested by the attending physician • Concurrent care – hospital inpatient care by a physician other than the attending physician for a condition not related to your primary diagnosis, or because the medical complexity of your condition requires this additional medical care • Physical therapy by a physician other than the attending physician • Initial examination of a newborn needing definitive treatment when covered under a family enrollment • Pharmacotherapy [see Section 5(c) for our coverage of drugs you receive while in the hospital] • Neurological testing • Second surgical opinion	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

Diagnostic and treatment services - continued on next page

Benefit Description	You Pay	
Diagnostic and treatment services (cont.)	**Standard Option**	**Basic Option**
• Nutritional counseling when billed by a covered provider	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
Not covered : • *Routine services except for those Preventive care services described on pages 32-34* • *Online medical evaluation and management services* • *Inpatient private duty nursing* • *Standby physicians* • *Routine radiological and staff consultations required by hospital rules and regulations* • *Inpatient physician care when your hospital admission or portion of an admission is not covered [see Section 5(c)]* ***Note:*** *If we determine that a hospital admission is not covered, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.*	*All charges*	*All charges*
Lab, X-ray and other diagnostic tests	**Standard Option**	**Basic Option**
Diagnostic tests provided, or ordered and billed by a physician, such as: • Blood tests • Bone density tests – screening or diagnostic • CT scans/MRIs • EKGs and EEGs • Genetic testing – diagnostic • Laboratory tests • Pathology services • Ultrasounds • Urinalysis • X-rays (including set-up of portable X-ray equipment) Diagnostic services billed by an independent laboratory	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Preferred primary care provider or other health care professional: Nothing Preferred specialist: Nothing ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You Pay	
Lab, X-ray and other diagnostic tests (cont.)	**Standard Option**	**Basic Option**
Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Preferred primary care provider or other health care professional: Nothing Preferred specialist: Nothing ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
Preventive care, adult	**Standard Option**	**Basic Option**
Home and office visits for routine (screening) physical examinations **Under Standard Option,** benefits are limited to the following services when performed as part of a routine physical examination: • History and risk assessment • Chest X-ray • EKG • Urinalysis • General health panel • Basic or comprehensive metabolic panel test • CBC • Fasting lipoprotein profile (total cholesterol, LDL, HDL, and/or triglycerides) when performed by a Preferred provider or any independent laboratory • Screening and behavioral change interventions for tobacco use and alcohol/substance abuse ***Note:*** The benefits listed above do not apply to children up to age 22. (See benefits under *Preventive care, children*, this section.) • Chlamydial infection test **Under Basic Option,** benefits are provided for all of the services listed above and for other appropriate screening tests and services.	Preferred: $20 copayment for the examination (No deductible); nothing for services or tests ***Note:*** We provide benefits for adult routine physical examinations only when you receive these services from a **Preferred provider**. Participating: You pay all charges Non-participating: You pay all charges ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. ***Note:*** See Section 5(c) for our payment levels for these services when billed for by a facility, such as the outpatient department of a hospital.
Not covered:	*All charges*	*All charges*

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	**Standard Option**	**Basic Option**
• *Preventive medicine counseling and/or risk factor reduction intervention, except as stated above for tobacco use and alcohol/substance abuse* • *Interpretation of health risk assessments* • *Self-administered health risk assessments*	*All charges*	*All charges*
Cancer diagnostic tests and screening procedures • Colorectal cancer tests, including: - Fecal occult blood test - Colonoscopy (see page 52 for our payment levels for diagnostic colonoscopies billed for by a physician) - Sigmoidoscopy - Double contrast barium enema • Prostate cancer tests – Prostate Specific Antigen (PSA) test • Cervical cancer tests (including Pap tests) • Breast cancer tests (mammograms) Other diagnostic and screening procedures • Ultrasound for aortic abdominal aneurysm ***Note:*** Benefits are not available for genetic testing related to family history of cancer or other disease.	Preferred: $20 copayment for associated office visits (No deductible); nothing for services or tests ***Note:*** We provide benefits in full for preventive (screening) tests and immunizations only when you receive these services from a **Preferred provider** on an outpatient basis. If these services are billed separately from the routine physical examination, you may be responsible for paying an additional copayment for each office visit billed. Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. ***Note:*** See Section 5(c) for our payment levels for these services when billed for by a facility, such as the outpatient department of a hospital.
Routine immunizations (as licensed by the U.S. Food and Drug Administration), limited to: • Hepatitis immunizations (Types A and B) for patients with increased risk or family history • Herpes Zoster (shingles) vaccines • Human Papillomavirus (HPV) vaccines • Influenza (one each flu season) and pneumococcal vaccines ***Note:*** See page 90 for our coverage of influenza (flu) vaccines provided by Preferred retail pharmacies. • Meningococcal vaccines	Preferred: $20 copayment for associated office visits (No deductible); nothing for immunizations Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment for associated office visits; nothing for immunizations Preferred specialist: $30 copayment for associated office visits; nothing for immunizations Participating/Non-participating: You pay all charges

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	**Standard Option**	**Basic Option**
• Tetanus-diphtheria (Td) booster – once every 10 years	Preferred: $20 copayment for associated office visits (No deductible); nothing for immunizations Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $25 copayment for associated office visits; nothing for immunizations Preferred specialist: $30 copayment for associated office visits; nothing for immunizations Participating/Non-participating: You pay all charges ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.
Not covered: Office visit charges associated with preventive services and routine immunizations performed by Participating and Non-participating providers	*All charges*	*All charges*
Preventive care, children	**Standard Option**	**Basic Option**
We provide benefits for the following services: • All healthy newborn visits including routine screening (inpatient or outpatient) • The following routine services as recommended by the American Academy of Pediatrics for children up to the age of 22, including children living, traveling, or adopted from outside the United States: - Routine physical examinations - Routine hearing tests - Laboratory tests - Immunizations - Human Papillomavirus (HPV) vaccines - Meningococcal vaccine - Rotavirus vaccines - Related office visits	Preferred: Nothing (No deductible) Participating: Nothing (No deductible) Non-participating: Nothing (No deductible) up to the Plan allowance. You are responsible only for any difference between our allowance and the billed amount. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: Nothing Preferred specialist: Nothing Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.

Benefit Description	You Pay	
Maternity care	**Standard Option**	**Basic Option**
Complete maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage when provided, or ordered and billed by a physician or nurse midwife, such as: • Prenatal care (including ultrasound, laboratory, and diagnostic tests) • Tocolytic therapy and related services (when provided and billed by a home infusion therapy company or a home health care agency) ***Note:*** Benefits are not provided for oral tocolytic agents. Benefits for home nursing visits related to covered tocolytic therapy are subject to the visit limitations described on page 47. • Delivery • Postpartum care • Assistant surgeons/surgical assistance if required because of the complexity of the delivery • Anesthesia (including acupuncture) when requested by the attending physician and performed by a certified registered nurse anesthetist (CRNA) or a physician other than the operating physician (surgeon) or the assistant	Preferred: Nothing (No deductible) ***Note:***For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use Preferred providers. Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance for the delivery itself and any other maternity related surgical procedures to be provided by a Non-participating physician when the charge for that care will be **$5,000 or more**. Call your Local Plan at the customer service number on the back of your ID card to obtain information about your coverage and the Plan allowance for the services. ***Note:***For anesthesia provided by a Non-participating anesthetist, you pay 100% of the billed amount up to a maximum of $800 per anesthetist per day (no deductible).	Preferred: Nothing ***Note:*** For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered inpatient services is limited to $100 per admission. For outpatient facility services related to maternity, see pages 69-71. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you are responsible only for any difference between our allowance and the billed amount.
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 15 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary.		

Maternity care - continued on next page

Benefit Description	You Pay	
Maternity care (cont.)	**Standard Option**	**Basic Option**
• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. ***Note:*** When a newborn requires definitive treatment including incubation charges by reason of prematurity or evaluation for medical or surgical reasons during or after the mother's confinement, the newborn is considered a patient in his or her own right. Regular medical or surgical benefits apply rather than maternity benefits. ***Note:*** See page 52 for our payment levels for circumcision.		
Not covered: • *Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest* • *Genetic testing of the baby's father*	*All charges*	*All charges*
Family Planning	**Standard Option**	**Basic Option**
A range of voluntary family planning services, limited to: • Depo-Provera • Diaphragms and contraceptive rings • Intrauterine devices (IUDs) • Implantable contraceptives • Oral and transdermal contraceptives • Voluntary sterilization [see *Surgical procedures* in Section 5(b)] ***Note:*** See Section 5(f) for prescription drug coverage.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay $100 for related surgical procedures. See Section 5(b) for our coverage for related surgical procedures. ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
Not covered: • *Reversal of voluntary surgical sterilization* • *Contraceptive devices not describe*	*All charges*	*All charges*

Benefit Description	You Pay	
Infertility services	**Standard Option**	**Basic Option**
Diagnosis and treatment of infertility, except as shown in *Not covered* ***Note:*** See Section 5(f) for prescription drug coverage.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
Not covered : • *Assisted reproductive technology (ART) procedures, such as:* - *artificial insemination (AI)* - *in vitro fertilization (IVF)* - *embryo transfer and Gamete Intrafallopian Transfer (GIFT)* - *intravaginal insemination (IVI)* - *intracervical insemination (ICI)* - *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures, such as sperm banking*	*All charges*	*All charges*
Allergy care	**Standard Option**	**Basic Option**
• Testing and treatment, including materials (such as allergy serum) • Allergy injections	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit; nothing for injections Preferred specialist: $30 copayment per visit; nothing for injections Participating/Non-participating: You pay all charges (except as noted below)

Allergy care - continued on next page

Benefit Description	You Pay	
Allergy care (cont.)	**Standard Option**	**Basic Option**
		Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
Not covered: Provocative food testingand sublingual allergy desensitization	*All charges*	*All charges*
Treatment therapies	**Standard Option**	**Basic Option**
Outpatient treatment therapies: • Chemotherapy and radiation therapy ***Note:*** We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under *Organ/tissue transplants* in Section 5(b). See also, *Other services* under *How to get approval for . . .* in Section 3 (page 17). • Renal dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy – Home IV or infusion therapy ***Note:*** Home nursing visits associated with Home IV/infusion therapy are covered as shown under Home health services on page 47. • Outpatient cardiac rehabilitation ***Note:*** See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
Inpatient treatment therapies: • Chemotherapy and radiation therapy ***Note:*** We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under *Organ/tissue transplants* in Section 5(b). See also, *Other services* under *How to get approval for . . .* in Section 3 (page 17). • Renal dialysis – Hemodialysis and peritoneal dialysis • Pharmacotherapy [see Section 5(c) for our coverage of drugs administered in connection with these treatment therapies]	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

Benefit Description	You Pay	
Physical therapy, occupational therapy, speech therapy, and cognitive therapy	**Standard Option**	**Basic Option**
• Physical therapy, occupational therapy, and speech therapy when performed by a licensed therapist or physician • Cognitive rehabilitation therapy when performed by a licensed therapist or physician ***Note:*** When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for professional care, according to the contracting status of the facility.	Preferred: $20 copayment per visit (No deductible) Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three. ***Note:*** Visits that you pay for while meeting your calendar year deductible count toward the limit cited above. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. ***Note:*** Benefits are limited to 50 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three. Participating/Non-participating: You pay all charges ***Note:*** See Section 5(c) for our payment levels for rehabilitative therapies billed for by the outpatient department of a hospital.
Not covered: • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Maintenance or palliative rehabilitative therapy* • *Exercise programs* • *Hippotherapy (exercise on horseback)* • *Services provided by massage therapists*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**Standard Option**	**Basic Option**
Hearing tests related to illness or injury	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies.

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You Pay	
Hearing services (testing, treatment, and supplies) (cont.)	**Standard Option**	**Basic Option**
		Participating/Non-participating: You pay all charges
Not covered: • *Routine hearing tests (except as indicated under Preventive care, children)* • *Hearing aids (except as described on page 43)* • *Testing and examinations for the prescribing or fitting of hearing aids(except as needed for covered hearing aids described on page 43)*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**Standard Option**	**Basic Option**
Benefits are limited to one pair of eyeglasses, replacement lenses, or contact lenses per incident prescribed: • To correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery; • In lieu of surgery when the condition can be corrected by surgery, but surgery is precluded because of age or medical condition ***Note:*** Benefits are provided for refractions only when the refraction is performed to determine the prescription for the one pair of eyeglasses, replacement lenses, or contact lenses provided per incident as described above.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
• Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 18 ***Note:*** See Section 5(b), *Surgical procedures*, for coverage for surgical treatment of amblyopia and strabismus.	Preferred: $20 copayment (No deductible) Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
Not covered: • *Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as described on page 41* • *Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described above*	*All charges*	*All charges*

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You Pay	
Vision services (testing, treatment, and supplies) (cont.)	**Standard Option**	**Basic Option**
• *LASIK, INTACS, radial keratotomy, and other refractive services except as described on page 41*	*All charges*	*All charges*
Foot care	**Standard Option**	**Basic Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes ***Note:*** See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts. ***Note:*** See Section 5(b) for our coverage for surgical procedures.	Preferred: $20 copayment for the office visit (No deductible); 15% of the Plan allowance for all other services (deductible applies) Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
Not covered: Routine foot care, such as cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above	*All charges*	*All charges*
Orthopedic and prosthetic devices	**Standard Option**	**Basic Option**
Orthopedic braces and prosthetic appliances such as: • Artificial limbs and eyes • Functional foot orthotics when prescribed by a physician • Rigid devices attached to the foot or a brace, or placed in a shoe • Replacement, repair, and adjustment of covered devices • Following a mastectomy, breast prostheses and surgical bras, including necessary replacements • Hearing aids for children up to age 22, limited to $1,000 per ear per calendar year • Hearing aids for adults age 22 and over, limited to $1,000 per ear per 36-month period ***Note:***See below for our coverage of bone anchored hearing aids. • Bone anchored hearing aids when medically necessary for members with traumatic injury or malformation of the external ear or middle ear (such as a surgically induced malformation or congenital malformation), limited to $1,000 per ear per calendar year***Note:*** Benefits for hearing aids are subject to the cost-sharing amounts shown to the right under the "You Pay" columns.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay	
Orthopedic and prosthetic devices (cont.)	**Standard Option**	**Basic Option**
• Surgically implanted penile prostheses to treat erectile dysfunction ***Note:*** A **prosthetic appliance** is a device that is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body. We provide hospital benefits for internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b).	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
• Wigs (scalp hair prosthesis) due to hair loss due to chemotherapy for the treatment of cancer ***Note:*** Benefits for wigs are paid at 100% of the billed amount, limited to $350 for one wig per lifetime.	Any amount over $350 for one wig per lifetime (No deductible)	Any amount over $350 for one wig per lifetime
Not covered: • *Shoes and over-the-counter orthotics* • *Arch supports* • *Heel pads and heel cups* • *Wigs (including cranial prostheses), except for scalp hair prosthesis for hair loss due to chemotherapy for the treatment of cancer, as stated above*	*All charges*	*All charges*
Durable medical equipment (DME)	**Standard Option**	**Basic Option**
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Home dialysis equipment • Oxygen equipment • Hospital beds • Wheelchairs • Crutches	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable medical equipment (DME) (cont.)	**Standard Option**	**Basic Option**
• Walkers • Continuous passive motion (CPM) and dynamic orthotic cranioplasty (DOC) devices • Other items that we determine to be DME, such as compression stockings ***Note:*** We cover DME at Preferred benefit levels only when you use a Preferred DME provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred DME providers. ***Note:*** See Section 5(c) for our coverage of DME provided and billed by a facility.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
Not covered : • *Exercise and bathroom equipment* • *Lifts, such as seat, chair, or van lifts* • *Car seats* • *Air conditioners, humidifiers, dehumidifiers, and purifiers* • *Breast pumps* • *Communications equipment, devices, and aids (including computer equipment) such as "story boards" or other communication aids to assist communication-impaired individuals* • *Equipment for cosmetic purposes* • *Topical Hyperbaric Oxygen Therapy (THBO)*	*All charges*	*All charges*
Medical supplies	**Standard Option**	**Basic Option**
• Medical foods for children with inborn errors of amino acid metabolism • Medical foods and nutritional supplements when administered by catheter or nasogastric tubes • Medical foods, as defined by the U.S. Food and Drug Administration, that are administered orally and that provide the sole source (100%) of nutrition, for children up to age 22, for up to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate) ***Note:*** See Section 10, *Definitions*, for more information about medical foods. • Ostomy and catheter supplies • Oxygen • Blood and blood plasma, except when donated or replaced, and blood plasma expanders	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Medical supplies - continued on next page

Benefit Description	You Pay	
Medical supplies (cont.)	**Standard Option**	**Basic Option**
Note: We cover medical supplies at Preferred benefit levels only when you use a Preferred medical supply provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred medical supply providers.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
Not covered: Infant formulas used as a substitute for breastfeeding	*All charges*	*All charges*
Home health services	**Standard Option**	**Basic Option**
Home nursing care for two (2) hours per day, up to 25 visits per calendar year, when: • A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and • A physician orders the care	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Visits that you pay for while meeting your calendar year deductible count toward the annual visit limit.	Preferred: $25 copayment per visit Participating/Non-participating: You pay all charges
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for bathing, feeding, exercising, moving the patient, homemaking, giving medication, or acting as a companion or sitter* • *Services provided by a nurse, nursing assistant, health aide, or other similarly licensed or unlicensed person that are billed by a skilled nursing facility, extended care facility, or nursing home,* ***except*** *as included in the benefits described on page 72*	*All charges*	*All charges*
Chiropractic	**Standard Option**	**Basic Option**
• One office visit per calendar year • One set of X-rays per calendar year • Spinal manipulations ***Note:*** Benefits may be available for other covered services you receive from chiropractors in medically underserved areas. See page 12 for additional information.	Preferred: $20 copayment per visit (No deductible) Participating: 30% of the Plan allowance	Preferred: $25 copayment per visit ***Note:*** Benefits are limited to 20 manipulations per calendar year. Participating/Non-participating: You pay all charges

Chiropractic - continued on next page

Benefit Description	You Pay	
Chiropractic (cont.)	**Standard Option**	**Basic Option**
	Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Benefits are limited to 12 manipulations per calendar year. ***Note:*** Office visits, X-rays, and spinal manipulations that you pay for while meeting your calendar year deductible count toward the appropriate benefit limit.	
Alternative treatments	**Standard Option**	**Basic Option**
Acupuncture ***Note:*** See page 64 for our coverage of acupuncture when provided as anesthesia for covered surgery. ***Note:*** See page 35 for our coverage of acupuncture when provided as anesthesia for covered maternity care. ***Note:*** We may also cover services of certain alternative treatment providers in medically underserved areas. See page 12 for additional information.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Acupuncture must be performed and billed by a physician or licensed acupuncturist. ***Note:*** Benefits for acupuncture are limited to 24 visits per calendar year. ***Note:*** Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.	Preferred primary care physician: $25 copayment per visit Preferred physician specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. ***Note:*** Acupuncture must be performed and billed by a physician. Participating/Non-participating: You pay all charges
Not covered: • *Services you receive from noncovered providers such as:* - *naturopaths* - *hypnotherapists* • *Biofeedback* • *Self-care or self-help training*	*All charges*	*All charges*

Benefit Description	You Pay	
Educational classes and programs	**Standard Option**	**Basic Option**
• Smoking cessation ***Note:*** See Section 5(e) for our coverage of individual and group psychotherapy for smoking cessation and Section 5(f) for our coverage of smoking cessation drugs.	Preferred: $20 copayment for the office visit charge (No deductible); 15% of the Plan allowance for all other services (deductible applies) Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges
• Diabetic education when billed by a covered provider ***Note:*** We cover diabetic educators, dieticians, and nutritionists who bill independently only as part of a covered diabetic education program. • Nutritional counseling for up to 4 visits per year when billed by a covered provider ***Note:*** Nutritional counseling for the treatment of anorexia and bulimia is not subject to the 4-visit limitation. ***Note:***We cover dieticians and nutritionists who bill independently for nutritional counseling.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Nutritional counseling visits (for other than anorexia and bulimia) that you pay for while meeting your calendar year deductible count toward the 4-visit limit.	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges
Not covered: • *Marital, family, educational, or other counseling or training services when performed as part of an educational class or program* • *Premenstrual syndrome (PMS), lactation, headache, eating disorder (except as described above), and other educational clinics* • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Services performed or billed by a school or halfway house or a member of its staff*	*All charges*	*All charges*

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible is $300 per person ($600 per family). The calendar year deductible applies to almost all **Standard Option** benefits in this Section. We say "(No deductible)" to show when the calendar year deductible does not apply.
- **Under Standard Option,** we provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, pathologists, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See below and page 14 for the exceptions to this requirement.**
- **Under Basic Option,** we provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service.
- The amounts listed in this section are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL for the following surgical services if they are to be performed on an outpatient basis: surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 16 for more information.**
- **YOU MUST GET PRIOR APPROVAL for all organ transplant surgical procedures (except kidney and cornea transplants);** and if your surgical procedure requires an inpatient admission, **YOU MUST GET PRECERTIFICATION. Please refer to the prior approval and precertification information shown in Section 3 to be sure which services require prior approval or precertification.**
- Standard Option members may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be $5,000 or more. See page 17 for more information.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no deductible under Basic Option.		
Surgical procedures	**Standard Option**	**Basic Option**
A comprehensive range of services provided, or ordered and billed by a physician, such as: • Operative procedures • Treatment of fractures and dislocations, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Colonoscopy – diagnostic • Other endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery* on page 54) • Treatment of burns • Circumcision of newborn • Insertion of internal prosthetic devices. See Section 5(a) – *Orthopedic and prosthetic devices*, and Section 5(c) – *Other hospital services and supplies* – for our coverage for the device. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Assistant surgeons/surgical assistance if required because of the complexity of the surgical procedures • Gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures to treat morbid obesity – a condition in which an individual has a Body Mass Index (BMI) of 40 or more, or an individual with a BMI of 35 or more with co-morbidities who has failed conservative treatment; eligible members must be age 18 or over. Benefits are also available for diagnostic studies and a psychological examination performed prior to the procedure to determine if the patient is a candidate for the procedure. ***Note:*** **You must get prior approval for outpatient surgery for morbid obesity.** Please refer to page 16 for more information.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Surgical procedures - continued on next page

Benefit Description	You Pay	
Surgical procedures (cont.)	**Standard Option**	**Basic Option**
Note: When multiple surgical procedures that add time or complexity to patient care are performed during the same operative session, the Local Plan determines our allowance for the combination of multiple, bilateral, or incidental surgical procedures. Generally, we will allow a reduced amount for procedures other than the primary procedure. ***Note:*** We do not pay extra for "incidental" procedures (those that do not add time or complexity to patient care). ***Note:*** When unusual circumstances require the removal of casts or sutures by a physician other than the one who applied them, the Local Plan may determine that a separate allowance is payable.		
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby physician* • *Routine surgical treatment of conditions of the foot [see Section 5(a) – Foot care]* • *Cosmetic surgery* • *LASIK, INTACS, radial keratotomy, and other refractive surgery*	*All charges*	*All charges*
Reconstructive surgery	**Standard Option**	**Basic Option**
• Surgery to correct a functional defect • Surgery to correct a congenital anomaly – a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. ***Note:*** Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth. ***Note:*** **You must get prior approval for outpatient surgical correction of congenital anomalies.** Please refer to page 16 for more information. • Treatment to restore the mouth to a pre-cancer state • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of the patient's breasts - treatment of any physical complications, such as lymphedemas	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Reconstructive surgery - continued on next page

Benefit Description	You Pay	
Reconstructive surgery (cont.)	**Standard Option**	**Basic Option**
Note: Internal breast prostheses are paid as orthopedic and prosthetic devices [see Section 5(a)]. See Section 5(c) when billed by a facility. ***Note:*** If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. • Surgery for placement of penile prostheses to treat erectile dysfunction	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Not covered: • *Cosmetic surgery – any operative procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form – unless required for a congenital anomaly or to restore or correct a part of the body that has been altered as a result of accidental injury, disease, or surgery (does not include anomalies related to the teeth or structures supporting the teeth)* • *Surgeries related to sex transformation, sexual dysfunction, or sexual inadequacy, except as specifically shown*	*All charges*	*All charges*
Oral and maxillofacial surgery	**Standard Option**	**Basic Option**
Oral surgical procedures, limited to: • Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is necessary • Surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth ***Note:*** **You must get prior approval for outpatient surgery needed to correct accidental injuries as described above.** Please refer to page 16 for more information. • Excision of exostoses of jaws and hard palate • Incision and drainage of abscesses and cellulitis • Incision and surgical treatment of accessory sinuses, salivary glands, or ducts • Reduction of dislocations and excision of temporomandibular joints	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Oral and maxillofacial surgery - continued on next page

Benefit Description	You Pay	
Oral and maxillofacial surgery (cont.)	**Standard Option**	**Basic Option**
• Removal of impacted teeth ***Note:*** Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Not covered: • *Oral implants and transplants except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Surgical procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Surgical procedures involving dental implants or preparation of the mouth for the fitting or the continued use of dentures, except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Orthodontic care before, during, or after surgery, except for orthodontia associated with surgery to correct accidental injuries as specifically described above and in Section 5(g)*	*All charges*	*All charges*
Organ/tissue transplants	**Standard Option**	**Basic Option**
Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to *Other services* in Section 3 for prior approval procedures. ***Note:*** You must obtain prior approval (see page 17) for those transplants listed under *Prior Approval Requirements* on page 59. ***Note:*** Refer to pages 15-16 for information about precertification of inpatient care.		
Solid organ transplants are limited to: • Cornea	Preferred: 15% of the Plan allowance	Preferred: $100 copayment per performing surgeon

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
• Heart • Heart-lung • Kidney • Liver • Pancreas • Simultaneous pancreas-kidney • Simultaneous liver-kidney • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Single, double, or lobar lung • For members with end-stage cystic fibrosis, benefits for lung transplantation are limited to double lung transplants	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You may receive specific benefit information in advance about kidney and cornea transplants to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 17 for more information.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. The medical necessity limitation is considered satisfied if the patient meets the staging description. • Myeloablative allogeneic blood or marrow stem cell transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) - Chronic myelogenous leukemia - Fanconi's Anemia - Hemoglobinopathy (i.e., Sickle cell anemia, Thalassemia major) - High-risk neuroblastoma - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous blood or marrow stem cell transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
- Advanced non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) - Amyloidosis - High-risk neuroblastoma	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Blood or marrow stem cell transplants for: • Myeloablative allogeneic blood or marrow stem cell transplants for: - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Sickle cell anemia - Thalassemia major (homozygous beta-thalassemia) - X-linked lymphoproliferative syndrome • Autologous blood or marrow stem cell transplants for: - Amyloidosis - Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Pineoblastoma - Germ cell tumors	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:***If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Prior approval requirements: You must obtain prior approval (see page 17) from the Local Plan, for both the procedure and the facility, for the following transplant procedures:		

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
• Blood or marrow stem cell transplant procedures ***Note:*** See pages 60 and 61 for services related to blood or marrow stem cell transplants covered under clinical trials. • Autologous pancreas islet cell transplant • Heart • Heart-lung • Intestinal transplants (small intestine with or without other organs) • Liver • Lung (single, double, or lobar) • Pancreas • Simultaneous liver-kidney • Simultaneous pancreas-kidney		
Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or in a Blue Distinction Centers for Transplants facility in an approved clinical trial (1) For the following procedures, we provide benefits **only** when conducted at a Cancer Research Facility (see page 13) and only when performed as part of a clinical trial that meets the **requirements** listed on page 61: • Myeloablative allogeneic blood or marrow stem cell transplants for: - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Multiple myeloma • Nonmyeloablative allogeneic blood or marrow stem cell transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) - Amyloidosis - Breast cancer - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
- Colon cancer - Multiple myeloma - Myelodysplasia/Myelodysplastic syndromes - Myeloproliferative disorders - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcoma	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
• Autologous blood or marrow stem cell transplants for: - Breast cancer - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Epithelial ovarian cancer ***Note:*** If a non-randomized clinical trial for a blood or marrow stem cell transplant listed above meeting the **requirements** shown below is not available at a Cancer Research Facility where you are eligible, we will arrange for the transplant to be provided at a transplant facility designated by the Transplant Clinical Trials Information Unit. (2) For the following procedures we provide benefits **only** when performed in a specific NIH-sponsored, multi-center, comparative clinical trial and when the **requirements** listed below are met: • Autologous blood or marrow stem cell transplants for the following autoimmune diseases: - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis (3) **Requirements** for blood or marrow stem cell transplants covered under clinical trials: For these blood or marrow stem cell transplant procedures and related services or supplies covered only through clinical trials: • You must contact our Transplant Clinical Trials Information Unit at 1-800-225-2268 for prior approval (see page 17);	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**Standard Option**	**Basic Option**
• The clinical trial must be reviewed and approved by the Institutional Review Board of the Cancer Research Facility where the procedure is to be delivered; and • The patient must be properly and lawfully registered in the clinical trial, meeting all the eligibility requirements of the trial.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Related transplant services: • Extraction or reinfusion of blood or marrow stem cells as part of a covered allogeneic or autologous blood or marrow stem cell transplant • Harvesting, immediate preservation, and storage of stem cells when the autologous blood or marrow stem cell transplant has been scheduled or anticipated to be scheduled within an appropriate time frame for patients diagnosed at the time of harvesting with one of the conditions listed on pages 57, 58, or 61 ***Note:*** Benefits are available for charges related to fees for storage of harvested autologous blood or marrow stem cells related to a covered autologous stem cell transplant that has been scheduled or anticipated to be scheduled within an appropriate time frame. No benefits are available for any charges related to fees for long term storage of stem cells. • Collection, processing, storage, and distribution of cord blood only when provided as part of a blood or marrow stem cell transplant scheduled or anticipated to be scheduled within an appropriate time frame for patients diagnosed with one of the conditions listed on pages 57, 58, 60, or 61 • Related medical and hospital expenses of the donor, as part of a covered blood or marrow stem cell transplant procedure • Related services or supplies provided to the recipient ***Note:*** See Section 5(a) for coverage for related services, such as chemotherapy and/or radiation therapy and drugs administered to stimulate or mobilize stem cells for covered transplant procedures.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/Tissue Transplants at Blue Distinction Centers for Transplants

We participate in the Blue Distinction Centers for Transplants℠ program, a centers of excellence program for the organ/tissue transplants listed below. You will receive enhanced benefits if you use a Blue Distinction Centers for Transplants facility.

All members (including those who have Medicare Part A or another group health insurance policy as their primary payer) must contact us at the customer service number listed on the back of their ID card before obtaining services. You will be referred to the designated Plan transplant coordinator for information about Blue Distinction Centers for Transplants.

- Heart
- Heart-lung
- Liver
- Pancreas
- Simultaneous liver-kidney
- Simultaneous pancreas-kidney
- Single or double (bilateral) lung
- Lobar transplant (living donor lung)
- Blood or marrow stem cell transplants listed on pages 57, 58, 60, and 61
- Related transplant services listed on page 62

Note: Benefits for cornea, kidney-only, and intestinal transplants are not available through Blue Distinction Centers for Transplants. See page 56 for benefit information for these transplants.

Note: See Section 5(c) for our benefits for facility care.

Note: Members will not be responsible for separate cost-sharing for the included professional services (see page 13).

Note: See pages 57-61 for requirements related to blood or marrow stem cell transplant coverage.

Note: See page 13 for special instructions regarding all admissions to Blue Distinction Centers for Transplants.

Organ/tissue transplants	Standard Option	Basic Option
Not covered: • *Transplants for any diagnosis not listed as covered* • *Donor screening tests and donor search expenses, except those performed for full siblings or the unrelated actual donor* • *Implants of artificial organs, including those implanted as a bridge to transplant and/or as destination therapy*	*All charges*	*All charges*

Anesthesia	Standard Option	Basic Option
Anesthesia (including acupuncture) for covered medical or surgical services when requested by the attending physician and performed by: • a certified registered nurse anesthetist (CRNA), or • a physician other than the physician (or the assistant) performing the covered medical or surgical procedure Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Anesthesia services consist of administration by injection or inhalation of a drug or other anesthetic agent (including acupuncture) to obtain muscular relaxation, loss of sensation, or loss of consciousness. ***Note:*** See Section 5(c) for our payment levels for anesthesia services billed by a facility.	Preferred: 15% of the Plan allowance Participating: 30% of the Plan allowance Non-participating: 100% of the billed amount up to a maximum of $800 per anesthetist per day (No deductible)	Preferred: Nothing Participating/Non-participating: You pay all charges

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this section, unlike Sections 5(a) and 5(b), the **Standard Option** calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)" when it applies. The calendar year deductible is $300 per person ($600 per family) under Standard Option.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3 to be sure which services require precertification.
- **YOU MUST GET PRIOR APPROVAL for the following surgical services if they are to be performed on an outpatient basis: surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 16 for more information.**
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.
- The amounts listed in this section are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your inpatient surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are listed in Sections 5(a) or 5(b).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Benefit Description	You Pay	
Note: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.		
Inpatient hospital	**Standard Option**	**Basic Option**
Room and board, such as: • semiprivate or intensive care accommodations • general nursing care • meals and special diets	Preferred: $200 per admission copayment for unlimited days Member: $300 per admission copayment for unlimited days	Preferred: $100 per day copayment up to $500 per admission for unlimited days Member/Non-member: You pay all charges

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	**Standard Option**	**Basic Option**
Note: We cover a private room only when you must be isolated to prevent contagion, when your isolation is required by law, or when a Preferred or Member hospital only has private rooms. If a Preferred or Member hospital only has private rooms, we base our payment on the contractual status of the facility. If a Non-member hospital only has private rooms, we base our payment on the Plan allowance for your type of admission. Please see page 123 for more information.	Preferred: $200 per admission copayment for unlimited days Member: $300 per admission copayment for unlimited days Non-member: $300 per admission copayment for unlimited days, plus 30% of the Plan allowance, and any remaining balance after our payment ***Note:*** If you are admitted to a Non-member facility due to a **medical emergency or accidental injury**, you pay a $300 per admission copayment for unlimited days and we then provide benefits at 100% of the Plan allowance.	Preferred: $100 per day copayment up to $500 per admission for unlimited days Member/Non-member: You pay all charges
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs • Diagnostic laboratory tests, pathology services, MRIs, machine diagnostic tests, and X-rays • Administration of blood or blood plasma • Dressings, splints, casts, and sterile tray services • Internal prosthetic devices • Other medical supplies and equipment, including oxygen • Anesthetics and anesthesia services • Take-home items • Pre-admission testing recognized as part of the hospital admissions process • Nutritional counseling • Acute inpatient rehabilitation ***Note:*** Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 15 for other circumstances, such as extended stays for you or your baby. • If you need to stay longer in the hospital than initially planned, we will cover an extended stay if it is medically necessary. However, you must precertify the extended stay. See Section 3 for information on requesting additional days.	Preferred: $200 per admission copayment for unlimited days ***Note:*** For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use a Preferred facility. Member: $300 per admission copayment for unlimited days Non-member: $300 per admission copayment for unlimited days, plus 30% of the Plan allowance, and any remaining balance after our payment	Preferred: $100 per day copayment up to $500 per admission for unlimited days ***Note:*** For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered services is limited to $100 per admission. Member/Non-member: You pay all charges

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	**Standard Option**	**Basic Option**
• We pay inpatient hospital benefits for an admission in connection with the treatment of children up to age 22 with severe dental caries. We cover hospitalization for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. We provide benefits for dental procedures as shown in Section 5(g). ***Note:*** See pages 35-36 for other covered maternity services. ***Note:*** See page 47 for coverage of blood and blood products.	Preferred: $200 per admission copayment for unlimited days ***Note:*** For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use a Preferred facility. Member: $300 per admission copayment for unlimited days Non-member: $300 per admission copayment for unlimited days, plus 30% of the Plan allowance, and any remaining balance after our payment	Preferred: $100 per day copayment up to $500 per admission for unlimited days ***Note:*** For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered services is limited to $100 per admission. Member/Non-member: You pay all charges
Not covered: *Hospital room and board expenses when, in our judgement, a hospital admission or portion of an admission is:* • *Custodial or long term care* • *Convalescent care or a rest cure* • *Domiciliary care provided because care in the home is not available or is unsuitable* • *Not medically necessary, such as when services did not require the acute/subacute hospital inpatient (overnight) setting but could have been provided safely and adequately in a physician's office, the outpatient department of a hospital, or some other setting, without adversely affecting your condition or the quality of medical care you receive. Some examples are:* - *Admissions for, or consisting primarily of, observation and/or evaluation that could have been provided safely and adequately in some other setting (such as a physician's office)* - *Admissions primarily for diagnostic studies, laboratory and pathology services, X-rays, MRIs, or machine diagnostic teststhat could have been provided safely and adequately in some other setting (such as the outpatient department of a hospital or a physician's office)*	*All charges*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	**Standard Option**	**Basic Option**
Note: *If we determine that a hospital admission is one of the types listed above, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered servicesor supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.* • *Admission to noncovered facilities, such as nursing homes, extended care facilities, schools, residential treatment centers* • *Personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services* • *Inpatient private duty nursing*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**Standard Option**	**Basic Option**
Outpatient **medical services** performed and billed by a hospital or freestanding ambulatory facility, such as: • Use of special treatment rooms • Diagnostic tests, such as laboratory and pathology services, MRIs, machine diagnostic tests, and X-rays • Chemotherapy and radiation therapy • Intravenous (IV)/infusion therapy • Cardiac rehabilitation • Pulmonary rehabilitation • Physical, occupational, and speech therapy • Renal dialysis • Visits to the outpatient department of a hospital for non-emergency medical care • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced, and other biologicals • Dressings, splints, casts, and sterile tray services • Other medical supplies, including oxygen ***Note:*** See pages 76-80 for our payment levels for care related to a medical emergency or accidental injury.	Preferred facilities: 15% of the Plan allowance (calendar year deductible applies) ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the 15% coinsurance amount (and any deductible amount) and pay for covered services in full when you use a Preferred facility. Member facilities: 30% of the Plan allowance (calendar year deductible applies) Non-member facilities: 30% of the Plan allowance (calendar year deductible applies) ***Note:*** See pages 32-34 for our payment levels for covered preventive care services for adults and children. ***Note:*** See page 40 for our coverage of physical, occupational, and speech therapy.	Preferred: $50 copayment per day per facility (except for diagnostic tests as noted below) Member/Non-member: You pay all charges (except for diagnostic tests as noted below) ***Note:*** For outpatient diagnostic tests billed for by a Preferred, Member, or Non-member facility, you pay nothing. ***Note:*** For outpatient facility care related to maternity, including care at birthing facilities, we provide benefits as shown here, according to the contracting status of the facility. ***Note:*** See page 34 for our payment levels for routine adult immunizations and preventive care services for children.
Outpatient **surgery and related services** performed and billed for by a hospital or freestanding ambulatory facility, such as: • Operating, recovery, and other treatment rooms	Preferred facilities: 15% of the Plan allowance	Preferred: $50 copayment per day per facility (except for diagnostic tests as noted below)

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay	
Outpatient hospital or ambulatory surgical center (cont.)	**Standard Option**	**Basic Option**
• Anesthetics and anesthesia services • Pre-surgical testing performed within one business day of the covered surgical services • Facility supplies for hemophilia home care • Diagnostic tests, such as laboratory and pathology services, MRIs, machine diagnostic tests, and X-rays • Visits to the outpatient department of a hospital for non-emergency surgical care • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced, and other biologicals • Dressings, splints, casts, and sterile tray services • Other medical supplies, including oxygen ***Note:*** See page 71 for outpatient drugs, medical devices, and durable medical equipment billed for by a hospital or freestanding ambulatory facility. ***Note:*** See pages 76-80 for our payment levels for care related to a medical emergency or accidental injury. ***Note:*** We cover outpatient hospital services and supplies related to the treatment of children up to age 22 with severe dental caries. We cover outpatient care related to other types of dental procedures only when a non-dental physical impairment exists that makes the hospital setting necessary to safeguard the health of the patient. See Section 5(g), *Dental benefits*, for additional benefit information. ***Note:*** See pages 35-36 for other covered maternity services.	Preferred facilities: 15% of the Plan allowance ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the 15% coinsurance amount and pay for covered services in full when you use a Preferred facility. Member facilities: 30% of the Plan allowance Non-member facilities: 30% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $50 copayment per day per facility (except for diagnostic tests as noted below) Member/Non-member: You pay all charges (except for diagnostic tests as noted below) ***Note:***F or outpatient diagnostic tests billed for by a Preferred, Member, or Non-member facility, you pay nothing. ***Note:***Benefits for screening colonoscopies are subject to the cost-sharing amounts shown above. ***Note:*** For outpatient facility care related to maternity, including care at birthing facilities, we provide benefits as shown here, according to the contracting status of the facility.
Outpatient **drugs, medical devices, and durable medical equipment** billed for by a hospital or freestanding ambulatory facility, such as: • Prescribed drugs • Orthopedic and prosthetic devices • Durable medical equipment	Preferred facilities: 15% of the Plan allowance (calendar year deductible applies) ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive the 15% coinsurance amount (and any deductible amount) and pay for covered services in full when you use a Preferred facility.	Preferred: 30% of the Plan allowance ***Note:*** You may also be responsible for paying a $50 copayment per day per facility for outpatient services. Member/Non-member: You pay all charges

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay	
Outpatient hospital or ambulatory surgical center (cont.)	**Standard Option**	**Basic Option**
	Member facilities: 30% of the Plan allowance (calendar year deductible applies) Non-member facilities: 30% of the Plan allowance, plus any difference between our allowance and the billed amount (calendar year deductible applies)	***Note:*** For outpatient facility care related to maternity, including care at birthing facilities, we provide benefits as shown here, according to the contracting status of the facility.
Extended care benefits/Skilled nursing care facility benefits	**Standard Option**	**Basic Option**
Limited to the following benefits for Medicare Part A copayments: When Medicare Part A is the primary payer (meaning that it pays first) and has made payment, **Standard Option** provides limited secondary benefits. We pay the applicable Medicare Part A copayments incurred **in full** during the first through the 30th day of confinement for each benefit period (as defined by Medicare) in a qualified skilled nursing facility. A qualified skilled nursing facility is a facility that specializes in skilled nursing care performed by or under the supervision of licensed nurses, skilled rehabilitation services, and other related care, and meets Medicare's special qualifying criteria, but is not an institution that primarily cares for and treats mental diseases. If Medicare pays the first 20 days in full, Plan benefits will begin on the 21st day (when Medicare Part A copayments begin) and will end on the 30th day. ***Note:*** See page 40 for benefits provided for outpatient physical, occupational, speech, and cognitive rehabilitation therapy when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs. ***Note:*** **If you do not have Medicare Part A, we do not provide benefits for skilled nursing facility care.**	Preferred: Nothing Participating/Member: Nothing Non-participating/Non-member: Nothing ***Note:*** You pay all charges not paid by Medicare after the 30th day.	*All charges*

Benefit Description	You Pay	
Hospice care	**Standard Option**	**Basic Option**
Hospice care is an integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients in their homes. We provide **home hospice care** benefits for the services listed below for members with a life expectancy of six months or less **when prior approval is obtained from the Local Plan** and the home hospice agency is approved by the Local Plan. Our prior approval decision will be based upon the hospice treatment plan and clinical information provided to us. • Physician visits • Nursing care • Medical social services • Physical therapy • Services of home health aides (certified or licensed, if the state requires it, and provided by the home hospice agency)aides • Durable medical equipment rental • Prescription drugs • Medical supplies ***Note:*** We also cover pre-enrollment visits when provided by a physician who is employed by the home hospice agency and when billed by the agency employing the physician. Prior approval is not required for these types of visits. ***Note:*** If Medicare Part A is the primary payer for your hospice care, prior approval is not required. However, our benefits will be limited to those services listed above. ***Note:*** Benefits are not available for home hospice care, e.g., care given by a home health aide, that is provided and billed for by other than the approved home hospice agency when the same type of care is already being provided by the home hospice agency.	Nothing	Nothing
Inpatient hospice for members receiving home hospice care benefits: Benefits are provided for up to five (5) consecutive days in a hospital or a freestanding hospice inpatient facility. Each inpatient stay must be separated by at least 21 days. These covered inpatient hospice benefits are available only when inpatient services are necessary to:	Preferred: $200 per admission copayment Member: $300 per admission copayment Non-member: $300 per admission copayment plus 30% of the Plan allowance, and any remaining balance after our payment	Preferred: $100 per day copayment up to $500 per admission Member/Non-member: You pay all charges

Hospice care - continued on next page

Benefit Description	You Pay	
Hospice care (cont.)	**Standard Option**	**Basic Option**
• control pain and manage the patient's symptoms; or • provide an interval of relief (respite) to the family ***Note:*** **You are responsible for making sure that the home hospice care provider has received prior approval from the Local Plan** (see page 16 for instructions)**.** Please check with your Local Plan and/or your PPO directory for listings of approved agencies.	Preferred: $200 per admission copayment Member: $300 per admission copayment Non-member: $300 per admission copayment plus 30% of the Plan allowance, and any remaining balance after our payment	Preferred: $100 per day copayment up to $500 per admission Member/Non-member: You pay all charges
Not covered: Homemaker services	*All charges*	*All charges*
Ambulance	**Standard Option**	**Basic Option**
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and: • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required.	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required.	Preferred: Nothing (No deductible) Participating/Member or Non-participating/Non-member: Nothing (No deductible) ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible is $300 per person ($600 per family). The calendar year deductible applies to almost all **Standard Option** benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits, except in cases of medical emergency or accidental injury. Refer to the guidelines appearing below for additional information.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

What is an accidental injury?

An accidental injury is an injury caused by an external force or element such as a blow or fall and which requires immediate medical attention, including animal bites and poisonings. [See Section 5(g) for dental care for accidental injury.]

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

Basic Option benefits for emergency care

Under Basic Option, you are encouraged to seek care from Preferred providers in cases of accidental injury or medical emergency. However, if you need care immediately and cannot access a Preferred provider, we will provide benefits for the **initial** treatment provided in the emergency room of any hospital – even if the hospital is not a Preferred facility. We will also provide benefits if you are admitted directly to the hospital from the emergency room until your condition has been stabilized. In addition, we will provide benefits for emergency ambulance transportation provided by Preferred or Non-preferred ambulance providers if the transport is due to a medical emergency or accidental injury.

We provide emergency benefits when you have acute symptoms of sufficient severity – including severe pain – such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child.

Benefit Description	You pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option does not apply. There is no calendar year deductible under Basic Option.		
Accidental injury	**Standard Option**	**Basic Option**
• **Physician services** in the hospital outpatient department, urgent care center, or physician's office, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests • Related outpatient **hospital services** and supplies, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests ***Note:*** We pay Inpatient professional and hospital benefits if you are admitted [see Sections 5(a), 5(b), and 5(c)]. ***Note:*** See Section 5(g) for dental benefits for accidental injuries.	Preferred: Nothing (No deductible) Participating/Member: Nothing (No deductible) Non-participating/Non-member: Any difference between the Plan allowance and the billed amount (No deductible) ***Note:*** For professional care provided in an emergency room by a Non-participating emergency room physician, your responsibility is limited to 100% of the billed amount up to a maximum of $350 per visit (No deductible). See Section 5 (b) for our coverage of surgery and anesthesia provided by Non-participating professional providers other than the emergency room physician. ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, regular medical and outpatient hospital benefits apply. See Section 5(a), Medical services and supplies, Section 5(b), Surgical procedures, and Section 5(c), Outpatient hospital, for the benefits we provide.	Preferred emergency room: $75 copayment per visit Participating/Member emergency room: $75 copayment per visit Non-participating/Non-member emergency room: $75 copayment per visit ***Note:*** You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** If you are admitted directly to the hospital from the emergency room, you do not have to pay the $75 emergency room copayment. However, the $100 per day copayment for Preferred inpatient care still applies. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits. For the following places of service, you **must** receive care from a Preferred provider: **Preferred** urgent care center: $30 copayment per visit **Preferred** primary care provider or other health care professional's office: $25 copayment per visit **Preferred** specialist's office: $30 copayment per visit Participating/Member (for other than emergency room): You pay all charges Non-participating/Non-member (for other than emergency room): You pay all charges

Accidental injury - continued on next page

Benefit Description	You pay	
Accidental injury (cont.)	**Standard Option**	**Basic Option**
Not covered: • *Oral surgery except as shown in Section 5(b)* • *Injury to the teeth while eating* • *Emergency room physician charges for shift differentials*	*All charges*	*All charges*
Medical emergency	**Standard Option**	**Basic Option**
• **Physician services** in the hospital outpatient department, urgent care center, or physician's office, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests • Related outpatient **hospital services** and supplies, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests ***Note:*** We pay Inpatient professional and hospital benefits if you are admitted as a result of a medical emergency [see Sections 5(a), 5(b), and 5(c)]. ***Note:*** Please refer to Section 3 for information about precertifying emergency hospital admissions.	Preferred: 15% of the Plan allowance ***Note:*** If you receive services in a Preferred physician's office, you pay a $20 copayment (No deductible) for the office visit, and 15% of the Plan allowance for all other services (deductible applies). Participating/Member: 30% of the Plan allowance Non-participating/Non-member: 30% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** For professional care provided in an emergency room by a Non-participating emergency room physician, your responsibility is limited to 100% of the billed amount up to a maximum of $350 per visit (No deductible). See Section 5 (b) for our coverage of surgery and anesthesia provided by Non-participating professional providers other than the emergency room physician. ***Note:*** These benefit levels **do not** apply if you receive care in connection with, and within 72 hours after, an accidental injury. See Accidental Injury benefits on pages 76-78 for the benefits we provide.	Preferred emergency room: $75 copayment per visit Participating/Member emergency room: $75 copayment per visit Non-participating/Non-member emergency room: $75 copayment per visit ***Note:*** You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** If you are admitted directly to the hospital from the emergency room, you do not have to pay the $75 emergency room copayment. However, the $100 per day copayment for Preferred inpatient care still applies. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits. For the following places of service, you **must** receive care from a Preferred provider: **Preferred** urgent care center: $30 copayment per visit **Preferred** primary care provider or other health care professional's office: $25 copayment per visit **Preferred** specialist's office: $30 copayment per visit

Medical emergency - continued on next page

Benefit Description	You pay	
Medical emergency (cont.)	**Standard Option**	**Basic Option**
		Participating/Member (for other than emergency room): You pay all charges Non-participating/Non-member (for other than emergency room): You pay all charges
Not covered: Emergency room physician charges for shift differentials	*All charges*	*All charges*
Ambulance	**Standard Option**	**Basic Option**
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and: • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required. ***Note:*** See Section 5(c) for non-emergency ambulance services.	Preferred: $100 copayment per day for ground ambulance transport services (No deductible) Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services (No deductible) ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day (No deductible).	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required.	Preferred: Nothing (No deductible) Participating/Member or Non-participating/Non-member: Nothing (No deductible) ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.

Section 5(e). Mental health and substance abuse benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **YOU MUST CALL US FOR PRIOR APPROVAL BEFORE RECEIVING ANY OUTPATIENT PROFESSIONAL OR OUTPATIENT FACILITY CARE FROM PREFERRED PROVIDERS.** We will provide you with the names and phone numbers of several Preferred providers and tell you how many visits we are initially approving. You may then choose which of those providers you would like to see.
- **Under Standard Option,** the calendar year deductible or, for facility care, the inpatient per admission copay, applies to almost all benefits in this Section. We added "(No deductible)" to show when the deductible does not apply.
- **Under Standard Option,** there is a maximum of 25 visits per year for office visits, partial hospitalization, intensive outpatient treatment, and other hospital outpatient treatment. The first 25 visits under Standard Option each calendar year by Preferred providers and Non-preferred providers count toward this maximum. This maximum may be waived for services received from Preferred providers.
- **Under Standard Option,** you may choose to get care In-Network (Preferred) or Out-of-Network (Non-preferred). Cost-sharing and limitations for In-Network (Preferred) mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.**
- **Under Basic Option,** there is **no calendar year deductible**.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3. Some other services also require prior approval. See the instructions after the benefits descriptions below.
- **Standard Option and Basic Option benefits** for Preferred (In-Network) mental health and substance abuse care begin below and are continued on the following pages. Standard Option benefits for Non-preferred (Out-of-Network) care begin on page 85.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Preferred (In-Network) benefits	**Standard Option**	**Basic Option**
All diagnostic and treatment services for which prior approval is obtained. ***Note:*** Preferred benefits are payable only when we determine that the care is clinically appropriate to treat your condition and only when you receive the care from a Preferred provider.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Professional services, including individual or group therapy by psychiatrists, psychologists, clinical social workers, or psychiatric nurses • Office and home visits • In a hospital outpatient department (except for emergency rooms) • Psychotherapy for smoking cessation ***Note:*** Additional types of licensed providers may be available to you for mental health and substance abuse services. Consult your PPO directory or contact your Local Plan at the mental health and substance abuse phone number on the back of your ID card.	$20 copayment for the visit (No deductible)	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay a $50 copayment for outpatient services billed for by a facility. ***Note:*** You pay 30% of the Plan allowance for drugs and supplies.
• Pharmacotherapy (medication management) • Psychological testing	Preferred: $20 copayment for the office visit charge (No deductible)	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for drugs and supplies.
• Inpatient professional visits • Professional charges for facility-based intensive outpatient treatment	15% of the Plan allowance	Nothing
• Professional charges for intensive outpatient treatment in a provider's office or other professional setting	15% of the Plan allowance	Preferred: $30 copayment per visit
• Professional charges for outpatient diagnostic tests	15% of the Plan allowance	Nothing
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Diagnostic tests ***Note:*** You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	$200 per admission copayment (No deductible)	$100 per day copayment up to $500 per admission

Preferred (In-Network) benefits - continued on next page

Benefit Description	You Pay	
Preferred (In-Network) benefits (cont.)	**Standard Option**	**Basic Option**
Outpatient services provided and billed by a hospital or other covered facility • Diagnostic tests • Services in the following approved treatment programs (must be prior approved): - partial hospitalization - facility-based intensive outpatient treatment	15% of the Plan allowance	$50 copayment per day per facility ***Note:*** For outpatient diagnostic or psychological tests billed for by a Preferred, Member, or Non-member facility, you pay nothing. ***Note:*** You pay 30% of the Plan allowance for drugs.
Not covered: • *Services we have not approved* • *Educational or training services* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present* • *Services performed or billed by residential therapeutic camps (e.g., wilderness camps, Outward Bound, etc.)* • *Light boxes*	*All charges*	*All charges*

Authorization Procedures

Standard and Basic Options: To be eligible to receive Preferred mental health and substance abuse benefits, you must obtain prior approval (see below) and you must use a Preferred provider.

To locate a Preferred provider, please refer to your PPO directory, visit our Web site at www.fepblue.org, or contact us at the mental health and substance abuse phone number shown on the back of your ID card.

Precertification

You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty. Please refer to the precertification information listed in Section 3 for additional information.

Prior Approval

Standard and Basic Options: Prior approval is required for all outpatient mental health and substance abuse services.

To obtain prior approval, you, someone acting on your behalf, your physician, or your hospital must call us at the mental health and substance abuse phone number on the back of your ID card, **prior to starting treatment**. We will provide the names and phone numbers of several Preferred providers to choose from and tell you how many visits we are initially approving. We will not provide Preferred benefits for mental health and substance abuse services, even at Preferred facilities, until you obtain prior approval.

Treatment Plans

Standard and Basic Options: In order to maximize your benefits, we may request a treatment plan from your provider.

Preferred Limitation

Under Standard Option, if you do not obtain prior approval, we will provide only Non-preferred (out-of-network) benefits.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Non-preferred (Out-of-Network) benefits	**Standard Option**	**Basic Option**
Professional services, including individual or group therapy, by psychiatrists, psychologists, clinical social workers, or psychiatric nurses. All other types of Non-preferred providers are considered noncovered. As noted on page 87, if you use the services of a noncovered provider, no benefits are available. Call the Mental Health/Substance Abuse number on the back of your ID card to locate a Preferred provider. • Office and home visits • In a hospital outpatient department (except for emergency rooms) • Psychotherapy for smoking cessation	40% of the Plan allowance for up to 25 outpatient visits per calendar year; all charges after 25 visits*. You may also be responsible for any difference between the Plan allowance and the billed amount. *The 25-visit limit is a combined maximum for all outpatient professional care, partial hospitalization, intensive outpatient treatment, and outpatient facility care, whether performed by Preferred or Non-preferred providers, or applied to your calendar year deductible.	Participating/Non-participating: You pay all charges
Other services: • Pharmacotherapy (medication management) • Psychological testing	30% of the Plan allowance. You may also be responsible for any difference between the Plan allowance and the billed amount. ***Note:*** Other services are not subject to the 25-visit limitation.	Participating/Non-participating: You pay all charges
Inpatient visits	40% of the Plan allowance up to 100 days per calendar year; all charges after 100 days. You may also be responsible for any difference between the Plan allowance and the billed amount.	Participating/Non-participating: You pay all charges
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	$400 copayment per day (No deductible) up to 100 days per calendar year, plus any difference between our allowance and the billed amount; all charges after 100 days	Member/Non-member: You pay all charges
Outpatient services provided and billed by a hospital or other covered facility • Psychological testing	30% of the Plan allowance, plus any difference between the Plan allowance and the billed amount ***Note:*** Psychological testing is not subject to the visit limitations.	Member/Non-member: You pay all charges (except as noted below)

Non-preferred (Out-of-Network) benefits - continued on next page

Benefit Description	You Pay	
Non-preferred (Out-of-Network) benefits (cont.)	**Standard Option**	**Basic Option**
		Note: For outpatient diagnostic or psychological tests billed for by a Preferred, Member, or Non-member facility, you pay nothing.
Partial hospitalization and intensive outpatient treatment	30% of the Plan allowance, plus any difference between the Plan allowance and the billed amount; all charges after 25 visits* ***Note:*** Visits that you pay for while meeting your deductible count toward the limit cited above. *The 25-visit limit is a combined maximum for all outpatient professional care, partial hospitalization, intensive outpatient treatment, and outpatient facility care, whether performed by Preferred or Non-preferred providers, or applied to your calendar year deductible.	Participating/Member or Non-participating/Non-member: You pay all charges
Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a treatment facility for rehabilitative treatment of alcoholism or substance abuse	Non-preferred facility: $400 copayment per day, plus any difference between our allowance and the billed amount (No deductible); all charges after 28 days per lifetime Non-preferred professional: 40% of the Plan allowance; all charges after 28 days per lifetime. You may also be responsible for any difference between the Plan allowance and the billed amount. ***Note:*** Non-preferred inpatient care for the treatment of substance abuse is limited to one treatment program (28-day maximum) per lifetime.	Member/Non-member: You pay all charges Participating/Non-participating: You pay all charges
Not covered: • *Marital, family, educational, or other counseling or training services* • *Services performed by a noncovered provider*	*All charges*	*All charges*

Non-preferred (Out-of-Network) benefits - continued on next page

Benefit Description	You Pay	
Non-preferred (Out-of-Network) benefits (cont.)	**Standard Option**	**Basic Option**
• *Testing and treatment for learning disabilities and mental retardation* • *Services performed or billed by schools, residential treatment centers, halfway houses, or members of their staffs* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present* • *Services performed or billed by residential therapeutic camps (e.g., wilderness camps, Outward Bound, etc.)* • *Light boxes*	*All charges*	*All charges*

Lifetime maximum	Non-preferred inpatient care for the treatment of substance abuse is limited to one treatment program (28-day maximum) per lifetime under **Standard Option**.
Precertification	You must get precertification of the medical necessity of your admission to a hospital or other covered facility. Report emergency admissions within two business days following the day of admission, even if you have been discharged. Otherwise, benefits will be reduced by $500. See Section 3 for more information on precertification.

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your costs for covered services*, for information about catastrophic protection for mental health and substance abuse benefits.
- Section 7, *Filing a claim for covered services*, for information about submitting Non-preferred claims.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescription drugs and supplies, as described in the chart beginning on page 90.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible does **not** apply to prescriptions filled through the Retail Pharmacy Program or Mail Service Prescription Drug Program. We added "(calendar year deductible applies)" when it applies.
- **Under Basic Option,** there is **no calendar year deductible**.
- **YOU MUST GET PRIOR APPROVAL FOR CERTAIN DRUGS, and prior approval must be renewed periodically. Please refer to the prior approval information shown on page 94 of this Section and in Section 3.** Prior approval is part of our Patient Safety and Quality Monitoring (PSQM) program. See page 94 of this Section for more information about this important program.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **Under Standard Option,** PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See page 14 for the exceptions to this requirement.**
- Please note that retail pharmacies and internet pharmacies that are Preferred under Standard Option are not necessarily Preferred under Basic Option. Refer to page 88 for information about locating Preferred pharmacies.
- **Under Standard Option,** you may use the Mail Service Prescription Drug Program to fill your prescriptions.
- **Under Basic Option,** the Mail Service Prescription Drug Program **is not** available.

We will send each new enrollee a combined prescription drug/Plan identification card. Standard Option members are eligible to use the Mail Service Prescription Drug Program and will also receive a mail service order form and a preaddressed reply envelope.

- **Who can write your prescriptions.** A physician or dentist licensed in the United States or Puerto Rico, or a nurse practitioner in states that permit it, must write your prescriptions [see Section 5(i) for drugs purchased overseas].
- **Where you can obtain them.**

Under Standard Option, you may fill prescriptions at a Preferred retail pharmacy, through a Preferred internet pharmacy, at a Non-preferred retail pharmacy, or through our Mail Service Prescription Drug Program. Under Standard Option, we pay a higher level of benefits when you use a Preferred retail pharmacy, a Preferred internet pharmacy, or our Mail Service Prescription Drug Program.

Under Basic Option, you must fill prescriptions only at a Preferred retail pharmacy or through a Preferred internet pharmacy in order to receive benefits.

- **We use an open formulary.** This is a list of preferred drugs selected to meet patient needs at a lower cost to us. If your physician believes a brand-name drug is necessary or there is no generic equivalent available, ask your physician to prescribe a brand-name drug from our formulary list.

Under Standard Option, we may ask your doctor to substitute a formulary drug in order to help control costs. We cover drugs that require a prescription (whether or not they are on our formulary list). Your cooperation with our cost-savings efforts helps keep your premium affordable.

Under Basic Option, we encourage you to ask your physician to prescribe a brand-name drug from our formulary list when your physician believes a brand-name drug is necessary or when there is no generic equivalent available. If you purchase a drug that is not on our formulary list, your cost will be higher. (We cover drugs that require a prescription whether or not they are on our formulary list.)

Note: Before filling your prescription, please check the formulary status of your medication. Other than changes resulting from new drugs or safety issues, the formulary list is updated once a year. Prescription drugs are reviewed by the Plan for safety and clinical efficacy. Drugs determined to be of equal therapeutic value and similar safety and efficacy are then evaluated on the basis of cost. Using lower cost formulary drugs will provide you with a high quality, cost-effective prescription drug benefit.

Our payment levels are generally categorized as:

Level I: Includes generic drugs

Level II: Includes formulary or preferred brand-name drugs

Level III: Includes non-formulary or non-preferred brand-name drugs

You can view our formulary on our Web site at www.fepblue.org or request a copy by mail by calling 1-800-624-5060 (TDD: 1-800-624-5077). Any savings we receive on the cost of drugs purchased under this Plan from drug manufacturers are credited to the reserves held for this Plan.

- **Generic equivalents.**

Standard Option: By submitting your prescription (or those of family members covered by the Plan) to your retail pharmacy or the Mail Service Prescription Drug Program, you authorize them to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a brand-name drug.

Basic Option: By filling your prescriptions (or those of family members covered by the Plan) at a Preferred retail pharmacy or through a Preferred internet pharmacy, you authorize the pharmacist to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a brand-name drug.

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. In most cases, they must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration (FDA) sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

You can save money by using generic drugs. However, you and your doctor have the option to request a brand-name drug even if a generic option is available. Using the most cost-effective medication saves money.

- **Disclosure of information.** As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including the names of your prescribing physicians, to any treating physicians or dispensing pharmacies.
- **These are the dispensing limitations.**

Standard Option: Subject to manufacturer packaging and your prescriber's instructions, you may purchase **up to** a 90-day supply of covered drugs and supplies through the Retail Pharmacy Program. You may purchase a supply of **more than** 21 days **up to** 90 days through the Mail Service Prescription Drug Program for a single copayment.

Basic Option: When you fill a prescription for the first time, you may purchase **up to** a 34-day supply for a single copayment. For additional copayments, you may purchase **up to** a 90-day supply for continuing prescriptions and for refills.

Note: Certain drugs such as narcotics may have additional FDA limits on the quantities that a pharmacy may dispense. In addition, pharmacy dispensing practices are regulated by the state where they are located and may also be determined by individual pharmacies. Due to safety requirements, some medications are dispensed as originally packaged by the manufacturer and we cannot make adjustments to the packaged quantity or otherwise open or split packages to create 90-day supplies of those medications. In most cases, refills cannot be obtained until 75% of the prescription has been used. Call us or visit our Web site if you have any questions about dispensing limits. Please note that in the event of a national or other emergency, or if you are a reservist or National Guard member who is called to active military duty, you should contact us regarding your prescription drug needs. See the contact information below.

- **Important contact information.**

Standard Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077); Mail Service Prescription Drug Program: 1-800-262-7890 (TDD: 1-800-216-5343); or www.fepblue.org.

Basic Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077) or www.fepblue.org.

Benefits Description	You Pay	
Note: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies) ." There is no calendar year deductible under Basic Option.		
Covered medications and supplies	**Standard Option**	**Basic Option**
• Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase ***Note:*** See Section 5(a), page 47, for our coverage of medical foods for children and for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube. • Insulinand and diabetic test strips • Needles and disposable syringes for the administration of covered medications • Clotting factors and anti-inhibitor complexes for the treatment of hemophilia • Drugs to aid smoking cessation that require a prescription by Federal law ***Note:*** Prior approval is required if drug treatment extends beyond the initial course of treatment. See Section 3 for more information. • Contraceptive drugs and devices, limited to: - Depo-Provera* - Diaphragms and contraceptive rings* - Intrauterine devices (IUDs) - Implantable contraceptives* - Oral and transdermal contraceptives *available only through retail and internet pharmacies ***Note:*** See *Family planning* in Section 5(a).	See following pages	See following pages
• Influenza vaccine (one each flu season) provided by a Preferred retail pharmacy	Preferred retail pharmacy: Nothing	Preferred retail pharmacy: Nothing

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
	Non-preferred retail pharmacy: You pay all charges	Non-preferred retail pharmacy: You pay all charges
Here is how to obtain your prescription drugs and supplies: **Preferred Retail Pharmacies** • Make sure you have your Plan ID card when you are ready to purchase your prescription • Go to any Preferred retail pharmacy, or • Visit our Web site, www.fepblue.org, select the "Pharmacy" page, and click on the "Retail Pharmacy" link for your enrollment option (Standard or Basic) to fill your prescription and receive home delivery • For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site, www.fepblue.org ***Note:*** Please be sure to request the Preferred retail or internet pharmacy listing for your specific option. Retail and internet pharmacies that are Preferred under Standard Option are not necessarily Preferred under Basic Option. ***Note:*** Retail and internet pharmacies that are Preferred for prescription drugs are not necessarily Preferred for durable medical equipment (DME) and medical supplies. To receive Preferred benefits for DME and covered medical supplies, you must use a Preferred DME or medical supply provider. See Section 5(a) for the benefit levels that apply to DME and medical supplies. ***Note:*** For prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility, we provide benefits as shown on this page for retail pharmacy-obtained prescription drugs, as long as the pharmacy supplying the prescription drugs to the facility is a Preferred pharmacy. For a list of the Preferred Network Long Term Care pharmacies, call 1-800-624-5060 (TDD: 1-800-624-5077). **For benefit information about prescription drugs supplied by Non-preferred pharmacies, please refer to the next page.**	Level I (generic drug): 20% of the Plan allowance Level II & Level III (brand-name drug): 30% of the Plan allowance	**First-time purchase of a new prescription** up to a 34-day supply: Level I (generic drug): $10 copayment Level II (formulary or preferred brand-name drug): $35 copayment Level III (non-formulary or non-preferred brand-name drug): 50% of Plan allowance ($45 minimum) **Refills or continuing prescriptions** up to a 90-day supply: Level I (generic drug): $10 copayment for each purchase of up to a 34-day supply ($30 copayment for 90-day supply) Level II (formulary or preferred brand-name drug): $35 copayment for each purchase of up to a 34-day supply ($105 copayment for 90-day supply) Level III (non-formulary or non-preferred brand-name drug): 50% of Plan allowance ($45 minimum for each purchase of up to a 34-day supply, or $135 minimum for 90-day supply) ***Note:*** If there is no generic equivalent available, you must still pay the brand-name copayment when you receive a brand-name drug.

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
Note: For coordination of benefits purposes, if you need a statement of Preferred retail pharmacy benefits in order to file claims with your other coverage when this Plan is the primary payer, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site at www.fepblue.org.	Level I (generic drug): 20% of the Plan allowance Level II & Level III (brand-name drug): 30% of the Plan allowance	**First-time purchase of a new prescription** up to a 34-day supply: Level I (generic drug): $10 copayment Level II (formulary or preferred brand-name drug): $35 copayment Level III (non-formulary or non-preferred brand-name drug): 50% of Plan allowance ($45 minimum) **Refills or continuing prescriptions** up to a 90-day supply: Level I (generic drug): $10 copayment for each purchase of up to a 34-day supply ($30 copayment for 90-day supply) Level II (formulary or preferred brand-name drug): $35 copayment for each purchase of up to a 34-day supply ($105 copayment for 90-day supply) Level III (non-formulary or non-preferred brand-name drug): 50% of Plan allowance ($45 minimum for each purchase of up to a 34-day supply, or $135 minimum for 90-day supply) ***Note:*** If there is no generic equivalent available, you must still pay the brand-name copayment when you receive a brand-name drug. ***Note:*** When a therapeutically equivalent generic product becomes available, we may classify the Level II brand-name product as a Level III brand-name drug in determining how much you pay for the drug.

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
		Note: For generic and brand-name drug purchases, if the cost of your prescription is less than your cost-sharing amount noted above, you pay only the cost of your prescription.
Non-preferred Retail Pharmacies	45% of the Plan allowance (Average wholesale price – AWP), plus any difference between our allowance and the billed amount ***Note:*** If you use a Non-preferred retail pharmacy, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.	*All charges*
Mail Service Prescription Drug Program Under Standard Option, if your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you can use this service for your prescriptions and refills. Please refer to Section 7 for instructions on how to use the Mail Service Prescription Drug Program. ***Note:*** Not all drugs are available through the Mail Service Prescription Drug Program.	Mail Service Program: Generic: $10 copayment per generic prescription filled (and/or refill ordered) ***Note:*** The $10 copayment amount is waived for the first 4 generic prescriptions filled (and/or refills ordered) per calendar year. Brand-name: $65 for first 30 brand-name prescriptions filled (and/or refills ordered) per calendar year; $50 per brand-name prescription/refill thereafter ***Note:*** If there is no generic equivalent available, you must still pay the brand-name copayment when you receive a brand-name drug.	No benefit ***Note:*** You may request home delivery of your internet prescription drug purchases. See page 91 of this Section for our payment levels for drugs obtained through Preferred retail and internet pharmacies.

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
	Note: If the cost of your prescription is less than your copayment, you pay only the cost of your prescription. The Mail Service Prescription Drug Program will charge you the lesser of the prescription cost or the copayment when you place your order. If you have already sent in your copayment, they will credit your account with any difference.	
Drugs from other sources • Covered prescription drugs and supplies not obtained at a retail pharmacy, through an internet pharmacy, or, for Standard Option only, through the Mail Service Prescription Drug Program ***Note:*** Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription. ***Note:*** For covered prescription drugs and supplies purchased outside of the United States and Puerto Rico, please submit claims on an Overseas Claim Form. See Section 5(i) for information on how to file claims for overseas services. • Please refer to the Sections indicated for additional benefit information when you purchase drugs from a: - Physician's office – Section 5(a) - Hospital (inpatient or outpatient) – Section 5(c) - Hospice agency – Section 5(c) • Please refer to page 91 for retail pharmacy-obtained prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility	Preferred: 15% of the Plan allowance (calendar year deductible applies) Participating/Member: 30% of the Plan allowance (calendar year deductible applies) Non-participating/Non-member: 30% of the Plan allowance (calendar year deductible applies); plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Member or Non-participating/Non-member: You pay all charges
Patient Safety and Quality Monitoring (PSQM) We have a special program to promote patient safety and monitor health care quality. Our Patient Safety and Quality Monitoring (PSQM) program features a set of closely aligned programs that are designed to promote the safe and appropriate use of medications. Examples of these programs include: • Prior approval – As described below, this program requires that approval be obtained for certain prescription drugs and supplies before we provide benefits for them.		

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
• Safety checks – Before your prescription is filled, we perform quality and safety checks for usage precautions, drug interactions, drug duplication, excessive use, and frequency of refills. • Quantity allowances – Specific allowances for several medications are based on FDA-approved recommendations, clinical studies, and manufacturer guidelines. For more information about our PSQM program, including listings of drugs subject to prior approval or quantity allowances, visit our Web site at www.fepblue.org or call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077). **Prior Approval** As part of our Patient Safety and Quality Monitoring (PSQM) program (see above), **you must make sure that your physician obtains prior approval for certain prescription drugs and supplies in order to use your prescription drug coverage**. In providing prior approval, we may limit benefits to quantities prescribed in accordance with accepted standards of medical, dental, or psychiatric practice in the United States. Prior approval must be renewed periodically. To obtain a list of these drugs and supplies and to obtain prior approval request forms, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077). You can also obtain the list through our Web site at www.fepblue.org. Please read Section 3 for more information about prior approval. ***Note:*** If your prescription requires prior approval and you have not yet obtained prior approval, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.		
Not covered: • *Medical supplies such as dressings and antiseptics* • *Drugs and supplies for cosmetic purposes* • *Drugs and supplies for weight loss* • *Drugs for orthodontic care, dental implants, and periodontal disease* • *Medications and orally taken nutritional supplements that do not require a prescription under Federal law even if your doctor prescribes them or if a prescription is required under your State law*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefits Description	You Pay	
Covered medications and supplies (cont.)	**Standard Option**	**Basic Option**
Note: *See Section 5(a), page 47, for our coverage of medical foods for children and for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.* • *Drugs for which prior approval has been denied or not obtained* • *Infant formula other than described on page 47* • *Drugs and supplies related to sex transformations, sexual dysfunction, or sexual inadequacy* • *Drugs purchased through the mail or internet from pharmacies outside the United States by members located in the United States*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be the primary payer for any covered services and your FEDVIP Plan will be secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage*,for additional information.
- **Under Standard Option,** the calendar year deductible applies only to the accidental injury benefit below. We added "(calendar year deductible applies)" when it applies.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits, except in cases of dental care resulting from an accidental injury as described below.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- ***Note:*** We cover inpatient and outpatient hospital care, as well as anesthesia administered at the facility, to treat children up to age 22 with severe dental caries. We cover these services for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient (even if the dental procedure itself is not covered). See Section 5(c) for inpatient and outpatient hospital benefits.

Accidental injury benefit	You Pay	
Accidental injury benefit	**Standard Option**	**Basic Option**
We provide benefits for services, supplies, or appliances for dental care necessary to promptly repair injury to sound natural teeth required as a result of, and directly related to, an accidental injury. ***Note:*** An **accidental injury** is an injury caused by an external force or element such as a blow or fall and that requires immediate attention. Injuries to the teeth while eating are not considered accidental injuries. ***Note:*** A **sound natural tooth** is a tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.	Preferred: 15% of the Plan allowance (calendar year deductible applies) Participating: 30% of the Plan allowance (calendar year deductible applies) Non-participating: 30% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the billed amount ***Note:*** Under Standard Option, we first provide benefits as shown in the Schedule of Dental Allowances on the following pages. We then pay benefits as shown here for any balances.	$25 copayment ***Note:*** **We provide benefits for accidental dental injury care in cases of medical emergency when performed by Preferred or Non-preferred providers.** See Section 5(d) for the criteria we use to determine if emergency care is required. You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.

Dental Benefits

What is Covered

Standard Option dental benefits are presented in the chart beginning below and continuing on the following pages.

Basic Option dental benefits appear on page 101.

Note: See Section 5(b) for our benefits for Oral and maxillofacial surgery, and Section 5(c) for our benefits for hospital services (inpatient/outpatient) in connection with dental services, available under both Standard Option and Basic Option.

Preferred Dental Network

All Local Plans contract with Preferred dentists who are available in most areas. Preferred dentists agree to accept a negotiated, discounted amount called the Maximum Allowable Charge (MAC) as payment in full for the following services. They will also file your dental claims for you. Under Standard Option, you are responsible, as an out-of-pocket expense, for the difference between the amount specified in this Schedule of Dental Allowances and the MAC. To find a Preferred dentist near you, refer to the Preferred provider directory, visit our Web site at www.fepblue.org, or call us at the customer service number on the back of your ID card. You can also call us to obtain a copy of the applicable MAC listing.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

Standard Option dental benefits

Under Standard Option, we pay billed charges for the following services, up to the amounts shown per service as listed in the Schedule of Dental Allowances below and on the following pages. This is a complete list of dental services covered under this benefit for Standard Option. There are no deductibles, copayments, or coinsurance. When you use Non-preferred dentists, you pay all charges in excess of the listed fee schedule amounts. For Preferred dentists, you pay the difference between the fee schedule amount and the MAC (see above).

Standard Option dental benefits	Standard Option Only		
Covered service	**We Pay**	**We Pay**	**You pay**
Clinical oral evaluations	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left ***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Periodic oral evaluation*	$12	$8	
Limited oral evaluation	$14	$9	
Comprehensive oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	
**Limited to two per person per calendar year*			

Covered service - continued on next page

Standard Option dental benefits	Standard Option Only		
Covered service (cont.)	**We Pay**	**We Pay**	**You pay**
	To age 13	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
	$12	$8	
	$14	$9	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
	$14	$9	
	$14	$9	
Radiographs	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Intraoral complete series	$36	$22	
Intraoral periapical first film	$7	$5	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Intraoral periapical each additional film	$4	$3	
Intraoral occlusal film	$12	$7	
Extraoral first film	$16	$10	
Extraoral each additional film	$6	$4	
Bitewing – single film	$9	$6	
Bitewings – two films	$14	$9	
Bitewings – four films	$19	$12	
Bitewings – vertical	$12	$7	
Posterior-anterior or lateral skull and facial bone survey film	$45	$28	
Panoramic film	$36	$23	
Tests and laboratory exams	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Pulp vitality tests	$11	$7	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Palliative treatment	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
Palliative (emergency) treatment of dental pain – minor procedure	$24	$15	
Sedative filling	$24	$15	

Covered service - continued on next page

Standard Option dental benefits	Standard Option Only		
Covered service (cont.)	**We Pay**	**We Pay**	**You pay**
			Note: For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Preventive	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left ***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Prophylaxis – adult*	---	$16	
Prophylaxis – child*	$22	$14	
Topical application of fluoride (prophylaxis not included) – child	$13	$8	
Topical application of fluoride (prophylaxis not included) – adult	---	$8	
**Space maintenance (passive appliances)*	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left ***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Space maintainer – fixed – unilateral	$94	$59	
Space maintainer – fixed – bilateral	$139	$87	
Space maintainer – removable – unilateral	$94	$59	
Space maintainer – removable – bilateral	$139	$87	
Recementation of space maintainer	$22	$14	
Amalgam restorations (including polishing)	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left ***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Amalgam – one surface, primary or permanent	$25	$16	
Amalgam – two surfaces, primary or permanent	$37	$23	
Amalgam – three surfaces, primary or permanent	$50	$31	
Amalgam – four or more surfaces, primary or permanent	$56	$35	

**Limited to two per person per calendar year*

Covered service - continued on next page

Standard Option dental benefits	Standard Option Only		
Covered service (cont.)	**We Pay**	**We Pay**	**You pay**
Filled or unfilled resin restorations	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left ***Note:***For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Resin – one surface, anterior	$25	$16	
Resin – two surfaces, anterior	$37	$23	
Resin – three surfaces, anterior	$50	$31	
Resin – four or more surfaces or involving incisal angle (anterior)	$56	$35	
Resin-based composite – one surface, posterior	$25	$16	
Resin-based composite – two surfaces, posterior	$37	$23	
Resin-based composite – three surfaces, posterior	$50	$31	
Resin-based composite – four or more surfaces, posterior	$50	$31	
Inlay restorations	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left ***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Inlay – metallic – one surface	$25	$16	
Inlay – metallic – two surfaces	$37	$23	
Inlay – metallic – three or more surfaces	$50	$31	
Inlay – porcelain/ceramic – one surface	$25	$16	
Inlay – porcelain/ceramic – two surfaces	$37	$23	
Inlay – porcelain/ceramic – three or more surfaces	$50	$31	
Inlay – composite/resin – one surface	$25	$16	
Inlay – composite/resin – two surfaces	$37	$23	
Inlay – composite/resin – three or more surfaces	$50	$31	

Covered service - continued on next page

Standard Option dental benefits	Standard Option Only		
Covered service (cont.)	**We Pay**	**We Pay**	**You pay**
Other restorative services	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left *Note:* For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Pin retention – per tooth, in addition to restoration	$13	$8	
Extractions – includes local anesthesia and routine post-operative care			
Extraction, erupted tooth or exposed root	$30	$19	
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$43	$27	
Surgical removal of residual tooth roots (cutting procedure)	$71	$45	
General anesthesia in connection with covered extractions	$43	$27	
Not covered: Any service not specifically listed above	*Nothing*	*Nothing*	*All charges*

Basic Option dental benefits

Under Basic Option, we provide benefits for the services listed below. You pay a $20 copayment for each evaluation, and we pay any balances in full. This is a complete list of dental services covered under this benefit for Basic Option. You **must** use a Preferred dentist in order to receive benefits. For a list of Preferred dentists, please refer to the Preferred provider directory, visit our Web site at ww.fepblue.org, or call us at the customer service number on the back of your ID card.

Basic Option dental benefits	Basic Option Only	
Covered service	**We Pay**	**You Pay**
Clinical oral evaluations Periodic oral evaluation* Limited oral evaluation Comprehensive oral evaluation* *Benefits are limited to a combined total of 2 evaluations per person per calendar year	Preferred: All charges in excess of your $20 copayment Participating/Non-participating: Nothing	Preferred: $20 copayment per evaluation Participating/Non-participating: You pay all charges
Radiographs Intraoral – complete series including bitewings (*limited to 1 complete series every 3 years*) Bitewing – single film* Bitewings – two films*	Preferred: All charges in excess of your $20 copayment Participating/Non-participating: Nothing	Preferred: $20 copayment per evaluation Participating/Non-participating: You pay all charges

Covered service - continued on next page

Basic Option dental benefits	Basic Option Only	
Covered service (cont.)	**We Pay**	**You Pay**
Bitewings – four films* *Benefits are limited to a combined total of 4 films per person per calendar year	Preferred: All charges in excess of your $20 copayment Participating/Non-participating: Nothing	Preferred: $20 copayment per evaluation Participating/Non-participating: You pay all charges
Preventive Prophylaxis – adult *(up to 2 per calendar year)* Prophylaxis – child *(up to 2 per calendar year)** Topical application of fluoride (prophylaxis not included) – child *(up to 2 per calendar year)* Sealant – per tooth, first and second molars only *(once per tooth for children up to age 16 only)*	Preferred: All charges in excess of your $20 copayment Participating/Non-participating: Nothing	Preferred: $20 copayment per evaluation Participating/Non-participating: You pay all charges
Not covered: Any service not specifically listed above	*Nothing*	*All charges*

Section 5(h). Special features

Special feature	Description
Flexible benefits option	Under the Blue Cross and Blue Shield Service Benefit Plan, our Case Management process may include a **flexible benefits option**. This option allows nurse case managers at Local Plans to assist members with certain complex and/or chronic health issues by coordinating complicated treatment plans and other types of complex patient care plans. Through the flexible benefits option, case managers may identify a less costly alternative treatment plan for the member. Members who are eligible to receive services through the flexible benefits option are asked to provide verbal consent for the alternative plan. If you and your provider agree with the plan, alternative benefits will begin immediately and you will be asked to sign an **alternative benefits agreement** that includes the terms listed below. • Alternative benefits will be made available for a limited period of time and are subject to our ongoing review. You must cooperate with the review process. • If we approve alternative benefits, we cannot guarantee that they will be extended beyond the limited time period and/or scope of treatment initially approved or that they will be approved in the future. • The decision to offer alternative benefits is solely ours, and unless otherwise specified in the **alternative benefits agreement**, we may withdraw those benefits at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. If you sign the **alternative benefits agreement**, we will provide the agreed-upon benefits for the stated time period, unless we are misled by the information given to us. You may request an extension of the time period initially approved for alternative benefits, but benefits as stated in this brochure will apply if we do not approve your request. Please note that the written **alternative benefits agreement** must be signed by the member or his/her authorized representative and returned to the Plan case manager within 30 days of the date of the alternative benefits agreement. If the Plan does not receive the signed agreement within 30 days, alternative benefits will be withdrawn and benefits as stated in this brochure will apply.
Visit our new Web site!	We are pleased to announce that we have enhanced our Web site – www.fepblue.org – to better serve the health care needs of our Service Benefit Plan members. Now you can use the site to manage your health and your health care benefits with ease. Whether it's comparing benefit plans, choosing the coverage that best meets the needs of you and your family, or locating a provider near your home, www.fepblue.org allows you to understand your options and make informed decisions. Click on the new "My Blue" section to easily access a wide range of services such as checking the status of your claims, requesting claim forms, ordering a duplicate or replacement Service Benefit Plan ID card, changing your address of record, or finding the telephone number to talk to one of our customer service representatives. Visit the new health and wellness section for valuable information about healthy behaviors and lifestyles. The new www.fepblue.org is designed to give you quick access to the information you're looking for so that you can more easily understand and manage your health care benefits and your health care needs. That's why you'll find new search tools and easy-to-use features like the ability to increase text size at the touch of a button, print pages quickly, and e-mail Web site content. We hope you visit the new www.fepblue.org and take advantage of its many resources!

Special feature	Description
Blue Health Connection	Stay connected to your health and get the answers you need when you need them by using Blue Health Connection 24 hours a day, 365 days a year. This service offers you direct communication with a Registered Nurse by calling 1-888-258-3432 toll-free, or by accessing our Web site, www.fepblue.org. Blue Health Connection provides one-stop shopping for health information and health care management. You can check your symptoms with the Symptoms Checker, read information about healthy eating and weight loss, and listen to a range of health-related topics from the AudioHealth Library. In addition, you can complete a quick online Health Assessment that will help you look at your personal health, review your family history, and obtain personalized suggestions about health-related behaviors to improve or maintain your health and wellness. Please keep in mind that benefits for any health care services you may seek after using Blue Health Connection are subject to the terms of your coverage under this Plan.
Services for the deaf and hearing impaired	All Blue Cross and Blue Shield Plans provide TDD access for the hearing impaired to access information and receive answers to their questions.
Web accessibility for the visually impaired	Our Web site, www.fepblue.org, adheres to the most current Section 508 Web accessibility standards to ensure that visitors with visual impairments can use the site with ease. Select the "Web Accessibility" link and take advantage of special captioning, audio descriptions, screen reader optimization, enlarged text options, and high color contrast for enhanced visibility.
Travel benefit/services overseas	Please refer to Section 5(i) for benefit and claims information for care you receive outside the United States and Puerto Rico.
Health support programs	The Service Benefit Plan offers patient education and support programs for certain diagnoses in select locations. Call the customer service number on the back of your ID card to find out what programs are available in your area.
Healthy Families Program	Healthy Families is a national health education prevention program that provides educational mailings to members and their families to help adopt healthy behaviors, reduce risk of injury and disease, and improve existing chronic conditions.
***WalkingWorks®* Wellness Program**	*WalkingWorks®* can help you walk your way to better health through online tools and resources that encourage you to incorporate walking into your daily routine and to set – and achieve – personal wellness goals. Receive a pedometer to count your daily steps and then record your progress with the online *WalkingWorks* tracking tool. Log in at www.fepblue.org and start walking your way to better health. If you do not have access to the internet, please call us at 1-888-706-2583. *WalkingWorks* was developed in cooperation with the President's Council on Physical Fitness and Sports.

Section 5(i). Services, drugs, and supplies provided overseas

If you travel or live outside the United States and Puerto Rico, you are still entitled to the benefits described in this brochure. Unless otherwise noted in this Section, the same definitions, limitations, and exclusions also apply. See below and page 105 for the claims information we need to process overseas claims. We may request that you provide complete medical records from your provider to support your claim.

Please note that the requirements to obtain precertification for inpatient care and prior approval for those services listed in Section 3 do not apply when you receive care outside the United States.

Overseas claims payment

For professional care you receive overseas, we provide benefits at Preferred benefit levels using an Overseas Fee Schedule as our Plan allowance. **Under Standard Option,** you must pay any difference between our payment and the amount billed, in addition to any applicable deductible, coinsurance, and/or copayment amounts. You must also pay any charges for noncovered services.

Under Basic Option, you pay any difference between our payment and the amount billed, as well as the applicable copayment or coinsurance. You must also pay any charges for noncovered services. **The requirement to use Preferred providers in order to receive benefits under Basic Option does not apply when you receive care outside the United States and Puerto Rico.**

For facility care you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options** after you pay the applicable copayment or coinsurance. Standard Option members are also responsible for any amounts applied to the calendar year deductible for certain outpatient facility services – please see pages 69-71.

For dental care you receive overseas, we provide benefits as described in Section 5(g). **Under Standard Option,** you must pay any difference between the Schedule of Dental Allowances and the dentist's charge, in addition to any charges for noncovered services. **Under Basic Option,** you must pay the $20 copayment plus any difference between our payment and the dentist's charge, as well as any charges for noncovered services.

Worldwide Assistance Center

We have a network of participating hospitals overseas that will file your claims for inpatient facility care for you – without an advance payment for the covered services you receive. The Worldwide Assistance Center can help you locate a hospital in our network near where you are staying. You may also view a list of our network hospitals on our Web site, www.fepblue.org. Although we do not have a network of professionals overseas, the Worldwide Assistance Center can also help you locate a physician. You will have to file a claim to us for reimbursement for professional services.

If you are overseas and need assistance locating providers, contact the Worldwide Assistance Center (provided by Mondial Assistance – formerly World Access Service Corporation), by calling the center collect at 1-804-673-1678. Members in the United States, Puerto Rico, or the Virgin Islands should call 1-800-699-4337. Mondial Assistance also offers emergency evacuation services to the nearest facility equipped to adequately treat your condition, translation services, and conversion of foreign medical bills to U.S. currency. You may contact one of their multilingual operators 24 hours a day, 365 days a year.

Filing overseas claims

- **Hospital and physician care**

Most overseas providers are under no obligation to file claims on behalf of our members. **You may need to pay for the services at the time you receive them and then submit a claim to us for reimbursement.** To file a claim for covered hospital and physician services received outside the United States and Puerto Rico, send a completed Overseas Claim Form and itemized bills to: Mailroom Administrator, FEP Overseas Claims, P.O. Box 14133, Lexington, KY 40512-4113. We will provide translation and currency conversion services for your overseas claims. Send any written inquiries concerning the processing of your overseas claims to this address or call us at 1-888-999-9862, using the appropriate AT&T country codes available on our Web site under Contact Us. You may also obtain Overseas Claim Forms from this address, from our Web site (www.fepblue.org), or from your Local Plan.

Filing overseas claims

- **Pharmacy benefits**

Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription. To file a claim for covered drugs and supplies you purchase from pharmacies outside the United States and Puerto Rico, send a completed FEP Retail Prescription Drug Overseas Claim Form, along with itemized pharmacy receipts or bills, to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057. We will provide translation and currency conversion services for your overseas claims. You may obtain claim forms for your drug purchases by writing to this address, by visiting our Web site, www.fepblue.org, or by calling 1-888-999-9862, using the appropriate AT&T country codes available on our Web site under Contact Us. Send any written inquiries concerning drugs you purchase to this address as well.

Please note that under both **Standard and Basic Options**, you may fill your prescriptions through a Preferred internet pharmacy only if the prescribing physician is licensed in the United States or Puerto Rico.

Under Standard Option, you may order your prescription drugs from the Mail Service Prescription Drug Program only if:

- Your address includes a U.S. zip code (such as with APO and FPO addresses and in U. S. territories) and
- The prescribing physician is licensed in the United States or Puerto Rico.

Please see page 92 for more information about using this program.

The Mail Service Prescription Drug Program is not available under **Basic Option**.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB dispute regarding these benefits**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. In addition, these services are not eligible for benefits under the FEHB program. Please do not file a claim for

these services. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines.

For additional information, contact us at the phone number on the back of your ID card or visit our Web site at www.fepblue.org.

Discount Drug Program
The Discount Drug Program is available to Service Benefit Plan enrollees at no additional premium cost. It enables you to purchase, at discounted prices, certain prescription drugs that are not covered by the regular prescription drug benefit. Discounts vary by drug product, but average about 20%. The program permits you to obtain discounts on the following drugs:

For sexual dysfunction: Caverject injection, Cialis tablet, Edex injection, Levitra tablet, Muse suppository, and Viagra tablet;
For weight loss: Meridia capsule and Xenical capsule;
For hair removal: Vaniqa cream;
For hair growth: Propecia; and
For pigmenting/depigmenting: Alustra, Benoquin, Eldoquin, Epiquin Micro, Solaquin, Tretinoin, and Tri-Luma.

Drugs may be added to this list as they are approved by the Food and Drug Administration (FDA). To use the program, simply present a valid prescription and your Service Benefit Plan ID card at a network retail pharmacy. The pharmacist will ask you for payment in full at the negotiated discount rate. If you have any questions, please call 1-800-624-5060.

Federal DentalBlue
Federal DentalBlue is an optional dental product with an additional premium that supplements the dental benefits included in your Service Benefit Plan coverage. To apply for Federal DentalBlue, you must be:

1.1. Enrolled in Standard Option and reside in one of the following Plan areas: Alabama, Illinois, New Mexico, Oklahoma, Texas, or in the counties of Clallam, Columbia, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, or Yakima in Washington State; or

2.2. Enrolled in Basic Option and reside in one of the following Plan areas: Alabama, Illinois, New Mexico, Oklahoma, or Texas.

To purchase this additional coverage, complete and sign the Federal DentalBlue enrollment form, which you can obtain from your local Blue Cross and Blue Shield Plan. For more information on Federal DentalBlue, please contact us at:
Alabama: 1-800-492-8872 or www.bcbsal.org
Illinois: 1-866-431-1595 or www.yourfederaldental.com
New Mexico: 1-866-431-1604 or www.yourfederaldental.com
Oklahoma: 1-866-431-1602 or www.yourfederaldental.com
Texas: 1-866-431-1598 or www.yourfederaldental.com
Washington State Counties: 1-888-224-4366

Vision Care Affinity Program
Service Benefit Plan members can receive routine eye exams, frames, lenses, conventional contact lenses, and laser vision correction at substantial savings when using Davis Vision network providers. Members have access to over 27,000 providers including optometrists, ophthalmologists, and many retail centers. For a complete description of the program or to find a provider near you, visit us at www.fepblue.org or call **1-800-551-3337**between 8:00 a.m. and 11:00 p.m. eastern time, M-F;

9:00 a.m. to 4:00 p.m. on Sat.; and noon to 4:00 p.m. on Sun. Members can save on replacement contact lenses by visiting www.lens123.com or calling 1-800-536-7123. Members can also save up to 25% off the **provider's usual fee**, or 5% off sales pricing, on laser vision correction procedures. Call **1-800-551-3337**for the nearest location and authorization for the discount.

Medicare Advantage Plan Enrollment
Some local Blue Cross and Blue Shield Plans offer Medicare recipients the opportunity to enroll in a Medicare Advantage plan without payment of an FEHB premium. Contact your local Blue Cross and Blue Shield Plan for more information.

SNAPforSeniors®
SNAPforSeniors® (**S**earch **N**ew **A**vailable **P**laces) simplifies the difficult process of finding appropriate senior housing options by providing members with the Senior Housing Locator – an online tool to access a current, comprehensive database of more than 60,000 senior housing communities. By using the Senior Housing Locator, you can search for assisted living communities, residential care, nursing homes, continuing care retirement communities, and independent living communities anywhere in the nation. You can personalize your housing choices to best match the services and amenities available in each community to your lifestyle and health needs. The Senior Housing Locator can be accessed via www.fepblue.org.

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** (see specifics regarding transplants)**.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs, or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations, sexual dysfunction, or sexual inadequacy (except for surgical placement of penile prostheses to treat erectile dysfunction);
- Services, drugs, or supplies you receive from a provider or facility barred or suspended from the FEHB Program;
- Services, drugs, or supplies you would not be charged for if you had no health insurance coverage;
- Services, drugs, or supplies you receive without charge while in active military service;
- Amounts charged that neither you nor we are legally obligated to pay, such as amounts over the Medicare limiting charge or equivalent Medicare amount as described in Section 4 under *Your costs for covered services*, or State premium taxes, however applied;
- Services, drugs, or supplies you receive from immediate relatives or household members, such as spouse, parent, child, brother, or sister, by blood, marriage, or adoption;
- Services or supplies (except for medically necessary prescription drugs) that you receive from a noncovered facility, such as an extended care facility or nursing home, except as specifically described in Sections 5(a) and 5(c);
- Services, drugs, or supplies you receive from noncovered providers except in medically underserved areas as specifically described on page 12;
- Services, drugs, or supplies you receive for cosmetic purposes;
- Services, drugs, or supplies for the treatment of obesity, weight reduction, or dietary control, except for office visits and diagnostic tests for the treatment of morbid obesity; gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures (see page 52); and, those nutritional counseling services specifically listed on pages 30, 50, and 67;
- Services you receive from a provider that are outside the scope of the provider's licensure or certification;
- Any dental or oral surgical procedures or drugs involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for the fitting or continued use of dentures, except as specifically described in Section 5(g), *Dental benefits*, and Section 5(b) under *Oral and maxillofacial surgery*;
- Orthodontic care for malposition of the bones of the jaw or for temporomandibular joint (TMJ) syndrome;
- Services of standby physicians;
- Self-care or self-help training;
- Custodial care;
- Personal comfort items such as beauty and barber services, radio, television, or telephone;
- Furniture (other than medically necessary durable medical equipment) such as commercial beds, mattresses, chairs;

- Routine services, such as periodic physical examinations; screening examinations; immunizations; and services or tests not related to a specific diagnosis, illness, injury, set of symptoms, or maternity care, except for those preventive services specifically covered under *Preventive care, adult and child* in Sections 5(a) and 5(c) and screenings specifically listed on pages 32-34;
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay;
- Topical Hyperbaric Oxygen Therapy (THBO);
- Physician charges for shift differentials; or
- Services not specifically listed as covered.

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms or other claims filing advice, or answers to your questions about our benefits, contact us at the customer service number on the back of your Service Benefit Plan ID card, or at our Web site at www.fepblue.org.

In most cases, physicians and facilities file claims for you. Just present your Service Benefit Plan ID card when you receive services. Your physician must file on the CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form.

When you must file a claim – such as when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Use a separate claim form for each family member. For long or continuing hospital stays, or other long-term care, you should submit claims at least every 30 days. Bills and receipts should be itemized and show:

- Name of patient and relationship to enrollee;
- Plan identification number of the enrollee;
- Name and address of person or firm providing the service or supply;
- Dates that services or supplies were furnished;
- Diagnosis;
- Type of each service or supply; and
- The charge for each service or supply.

Note:Canceled checks, cash register receipts, balance due statements, or bills you prepare yourself are not acceptable substitutes for itemized bills.

In addition:

- You must send a copy of the explanation of benefits (EOB) form you received from any primary payer [such as the Medicare Summary Notice (MSN)] with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment, home nursing care, and physical, occupational, and speech therapy, require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies that are not received from the Retail Pharmacy Program, through a Preferred internet pharmacy, or through the Mail Service Prescription Drug Program must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, and charge. (See below for information on how to obtain benefits from the Retail Pharmacy Program, a Preferred internet pharmacy, and the Mail Service Prescription Drug Program.)

Prescription drug claims

Preferred Retail/Internet Pharmacies – When you use Preferred retail pharmacies, show your Service Benefit Plan ID card. Preferred retail pharmacies will file your claims for you. To use Preferred internet pharmacies, go to our Web site, www.fepblue.org, visit the "Pharmacy" page, and click on the "Retail Pharmacy" link for your enrollment option (Standard or Basic) to fill your prescriptions and receive home delivery. Be sure to have your Service Benefit Plan ID card ready to complete your purchase. We reimburse the Preferred retail or internet pharmacy for your covered drugs and supplies. You pay the applicable coinsurance or copayment.

Note: Even if you use Preferred pharmacies, you will have to file a paper claim form to obtain reimbursement if:

- You do not have a valid Service Benefit Plan ID card;
- You do not use your valid Service Benefit Plan ID card at the time of purchase; or
- You did not obtain prior approval when required (see page 17).

See the following paragraph for claim filing instructions.

Non-Preferred Retail/Internet Pharmacies

Standard Option: You must file a paper claim for any covered drugs or supplies you purchase at Non-preferred retail or internet pharmacies. Contact your Local Plan or call 1-800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired members with TDD equipment may call 1-800-624-5077. Follow the instructions on the prescription drug claim form and submit the completed form to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.

Basic Option: There are **no benefits** for drugs or supplies purchased at Non-preferred retail or internet pharmacies.

Mail Service Prescription Drug Program

Standard Option: We will send you information on our Mail Service Prescription Drug Program, including an initial mail order form. To use this program:

(1) Complete the initial mail order form;

(2) Enclose your prescription and copayment;

(3) Mail your order to Medco, P.O. Box 30496, Tampa, FL 33633-1524; and

(4) Allow approximately two weeks for delivery.

Alternatively, your physician may call in your initial prescription at 1-800-262-7890

(TDD: 1-800-216-5343). You will be billed later for the copayment.

After that, to order refills either call the same number or access our Web site at www.fepblue.org and either charge your copayment to your credit card or have it billed to you later. Allow approximately one week for delivery on refills.

Basic Option: The Mail Service Prescription Drug Program **is not** available under Basic Option.

Records

Keep a separate record of the medical expenses of each covered family member, because deductibles (under Standard Option) and benefit maximums (such as those for outpatient physical therapy or preventive dental care) apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible under Standard Option. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us your claim and appropriate documentation as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided you submitted the claim as soon as reasonably possible. If we return a claim or part of a claim for additional information, you must resubmit it within 90 days, or before the timely filing period expires, whichever is later.

Note: Once we pay benefits, there is a three-year limitation on the re-issuance of uncashed checks.

Overseas claims

Please refer to the claims filing information on pages 104 and 105 of this brochure.

When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for precertification or prior approval required by Section 3:

Step	Description
1	Ask us in writing to reconsider our initial decision. Write to us at the address shown on your explanation of benefits (EOB) form. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program or Mail Service Prescription Drug Program); and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, precertify your hospital stay or grant your request for prior approval for a service, drug, or supply); or b) Write to you and maintain our denial – go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information – if we did not send you a decision within 30 days after we received the additional information. Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 1, 1900 E Street, NW, Washington, DC 20415-3610. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and

- Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claims decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

a) We have not responded yet to your initial claim or request for precertification/prior approval, then call us at the customer service number on the back of your Service Benefit Plan ID card and we will expedite our review; or

b) We denied your initial claim or request for precertification/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 1 at 1-202-606-0727 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other group health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines. For example:

- If you are covered under our Plan as a dependent, any group health insurance you have from your employer will pay primary and we will pay secondary.
- If you are an annuitant under our Plan and also are actively employed, any group health insurance you have from your employer will pay primary and we will pay secondary.
- When you are entitled to the payment of health care expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payer and we are the secondary payer.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. For example, we will generally only make up the difference between the primary payer's benefits payment and 100% of the Plan allowance, subject to our applicable deductible (under Standard Option) and coinsurance or copayment amounts, except when Medicare is the primary payer (see Section 4). Thus, it is possible that the combined payments from both plans may not equal the entire amount billed by the provider.

Note: When we pay secondary to primary coverage you have from a prepaid plan (HMO), we base our benefits on your out-of-pocket liability under the prepaid plan (generally, the prepaid plan's copayments), subject to our deductible (under Standard Option) and coinsurance or copayment amounts.

In certain circumstances when we are secondary and there is no adverse effect on you (that is, you do not pay any more), we may also take advantage of any provider discount arrangements your primary plan may have and only make up the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan.

Note: Any visit limitations that apply to your care under this Plan are still in effect when we are the secondary payer.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage, and you must also send us documents about your other coverage if we ask for them.

Please see Section 4, *Your costs for covered services*, for more information about how we pay claims.

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age; and
- People with End Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on page 116.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

(Please refer to page 23 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. For example, you must continue to obtain prior approval for some prescription drugs and organ/tissue transplants before we will pay benefits. However, you do not have to precertify inpatient hospital stays when Medicare Part A is primary (see page 16 for exception).

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When the Original Medicare Plan is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for the covered charges. To find out if you need to do something to file your claims, call us at the customer service number on the back of your Service Benefit Plan ID card or visit our Web site at www.fepblue.org.

We waive some costs if the Original Medicare Plan is your primary payer – We will waive some out-of-pocket costs as follows:

When Medicare Part A is primary –

- Under **Standard Option**, we will waive our:
  - Inpatient hospital per-admission copayments;
  - Inpatient Non-member hospital coinsurance; and
  - Non-preferred inpatient per-day copayments for mental conditions/substance abuse care.
- Under **Basic Option**, we will waive our:
  - Inpatient hospital per-day copayments.

Note: Once you have exhausted your Medicare Part A benefits:

- Under **Standard Option**, you must then pay any difference between our allowance and the billed amount at Non-member hospitals.
- Under **Basic Option**, you must then pay the inpatient hospital per-day copayments.

When Medicare Part B is primary –

- Under **Standard Option**, we will waive our:
  - Calendar year deductible;
  - Coinsurance for services and supplies provided by physicians and other covered health care professionals (inpatient and outpatient, including mental conditions and substance abuse care);
  - Copayments for office visits to Preferred physicians and other health care professionals;
  - Copayments for routine physical examinations and preventive (screening) services performed by Preferred physicians, other health care professionals, and facilities; and
  - Outpatient facility coinsurance for medical, surgical, preventive, and mental conditions and substance abuse care.
- Under **Basic Option**, we will waive our:
  - Copayments and coinsurance for care received from covered professional and facility providers.

Note: We do not waive benefit limitations, such as the 25-visit limit for home nursing visits. In addition, we do not waive any coinsurance or copayments for prescription drugs.

- **Tell us about your Medicare coverage**

  You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Private contract with your physician**

  A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You may be responsible for paying the difference between the billed amount and the amount we paid.

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

  If you enroll in a Medicare Advantage plan, the following options are available to you:

  This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB Plan. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

  Under Standard Option, we will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles, if you receive services from providers who do not participate in the Medicare Advantage plan.

  Under Basic Option, we provide benefits for care received from Preferred providers when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area. However, we will not waive any of our copayments or coinsurance for services you receive from Preferred providers who do not participate in the Medicare Advantage plan. Please remember that you must receive care from Preferred providers in order to receive Basic Option benefits. See page 14 for the exceptions to this requirement.

  Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

  When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

- **Medicare prescription drug coverage (Part B)**

  This health plan **does not** coordinate its prescription drug benefits with Medicare Part B.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payer for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payer before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payer before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we pay benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if we provide benefits for that injury, you must agree to the following provisions:

- All recoveries you or your representativesobtain (whether by lawsuit, settlement, insurance or benefit program claims, orotherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or your representatives. For purposes of this provision, "you" includes your covered dependents, and "your representatives" include,if applicable, your heirs, administrators, legal representatives, parents (if you are a minor),successors, or assignees. This is our right of recovery.
- We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. Our right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.

- We will not reduce our share of any recovery unless,in the exercise of our discretion, we agree in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.
- You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must not take any action that may prejudice our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.

If you do seek damages for your illness or injury, you must tell us promptly that you have made a claim against another party for a condition that we have paid or may pay benefits for, you must seek recovery of our benefit payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a first priority lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you sign a reimbursement agreement and/or assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the signed reimbursement agreement and/or assignment, and we may enforce our right of recovery by offsetting future benefits.

Note: We will pay the costs of any covered services you receive that are in excess of any recoveries made.

Among the other situations covered by this provision, the circumstances in which we may subrogate or assert a right of recovery shall also include:

- When you are injured on premises owned by a third party; or
- When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:
  - No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by you to treat those benefits as secondary to this Plan
  - Uninsured and underinsured motorist coverage
  - Workers' Compensation benefits
  - Medical reimbursement coverage

Contact us if you need more information about subrogation.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)

Some FEHB plans already cover some dental and vision services. When you are covered by more than one dental/vision plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Section 10. Definitions of terms we use in this brochure

Accidental injury — An injury caused by an external force or element such as a blow or fall that requires immediate medical attention, including animal bites and poisonings. ***Note:*** Injuries to the teeth while eating are **not** considered accidental injuries. Dental care for accidental injury is limited to dental treatment necessary to repair sound natural teeth.

Admission — The period from entry (admission) as an inpatient into a hospital (or other covered facility) until discharge. In counting days of inpatient care, the date of entry and the date of discharge count as the same day.

Assignment — An authorization by the enrollee or spouse for us to issue payment of benefits directly to the provider. We reserve the right to pay you, the enrollee, directly for all covered services.

Calendar year — January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Carrier — The Blue Cross and Blue Shield Association, on behalf of the local Blue Cross and Blue Shield Plans.

Case management — A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes (Case Management Society of America, 2002). Each Blue Cross and Blue Shield Plan administers a case management program to assist Service Benefit Plan members with certain complex and/or chronic health issues. Each program is staffed by licensed health care professionals (Case Managers) and is accredited by URAC. For additional information regarding case management, call us at the telephone number listed on the back of your Service Benefit Plan ID card.

Coinsurance — Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 18.

Copayment — A copayment is a fixed amount of money you pay when you receive covered services. See page 18.

Cosmetic surgery — Any surgical procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form, except for repair of accidental injury, or to restore or correct a part of the body that has been altered as a result of disease or surgery or to correct a congenital anomaly.

Cost-sharing — Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services — Services we provide benefits for, as described in this brochure.

Custodial care — Treatment or services, regardless of who recommends them or where they are provided, that a person not medically skilled could perform safely and reasonably, or that mainly assist the patient with daily living activities, such as:

1. Personal care, including help in walking, getting in and out of bed, bathing, eating (by spoon, tube, or gastrostomy), exercising, or dressing;
2. Homemaking, such as preparing meals or special diets;
3. Moving the patient;
4. Acting as companion or sitter;
5. Supervising medication that can usually be self-administered; or

6. Treatment or services that any person can perform with minimal instruction, such as recording pulse, temperature, and respiration; or administration and monitoring of feeding systems.

Custodial care that lasts 90 days or more is sometimes known as Long Term Care. The Carrier, its medical staff, and/or an independent medical review determine which services are custodial care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies in a calendar year before we start paying benefits for those services. See page 18.

Durable medical equipment

Equipment and supplies that:

1. Are prescribed by your physician (i.e., the physician who is treating your illness or injury);
2. Are medically necessary;
3. Are primarily and customarily used only for a medical purpose;
4. Are generally useful only to a person with an illness or injury;
5. Are designed for prolonged use; and
6. Serve a specific therapeutic purpose in the treatment of an illness or injury.

Experimental or investigational services

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA); and, approval for marketing has not been given at the time it is furnished. ***Note:*** Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product, is experimental or investigational if:

1. Reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
2. Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only:

- published reports and articles in the authoritative medical and scientific literature;
- the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or
- the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or biological product or medical treatment or procedure.

Each Local Plan has a Medical Review department that determines whether a claimed service is experimental or investigational after consulting with internal or external experts or nationally recognized guidelines in a particular field or specialty.

For more detailed information, contact your Local Plan at the customer service telephone number located on the back of your Service Benefit Plan ID card.

Group health coverage

Health care coverage that you are eligible for based on your employment, or your membership in or connection with a particular organization or group, that provides payment for medical services or supplies, or that pays a specific amount of more than $200 per day for hospitalization (including extension of any of these benefits through COBRA).

Intensive outpatient care

A comprehensive, structured outpatient treatment program that includes extended periods of individual or group therapy sessions designed to assist members with mental health and/or substance abuse conditions. It is an intermediate setting between traditional outpatient therapy and partial hospitalization, typically performed in an outpatient facility or outpatient professional office setting. Program sessions may occur more than one day per week. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Lifetime maximum

The maximum amount the Plan will pay on your behalf for covered services you receive while you are enrolled in your option. Benefit amounts accrued are accumulated in a permanent record regardless of the number of enrollment changes. Please see page 87.

Local Plan

A Blue Cross and/or Blue Shield Plan that serves a specific geographic area.

Medical foods

The term medical food, as defined in Section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." In general, to be considered a medical food, a product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the product must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and the product must be intended to be used under medical supervision.

Medical necessity

We determine whether services, drugs, supplies, or equipment provided by a hospital or other covered provider are:

1. Appropriate to prevent, diagnose, or treat your condition, illness, or injury;
2. Consistent with standards of good medical practice in the United States;
3. Not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4. Not part of or associated with scholastic education or vocational training of the patient; and
5. In the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.

Mental conditions/ substance abuse

Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD; or disorders listed in the ICD requiring treatment for abuse of, or dependence upon, substances such as alcohol, narcotics, or hallucinogens.

Partial hospitalization

An intensive facility-based treatment program during which an interdisciplinary team provides care related to mental health and/or substance abuse conditions. Program sessions may occur more than one day per week and may be full or half days, evenings, and/or weekends. The duration of care per session is less than 24 hours. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. If the amount your provider bills for covered services is less than our allowance, we base our payment, and your share (coinsurance, deductible, and/or copayments), on the billed amount. We determine our allowance as follows:

- **PPO providers -** Our allowance (which we may refer to as the "PPA" for "Preferred Provider Allowance") is the negotiated amount that Preferred providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with each local Blue Cross and Blue Shield Plan, and retail and internet pharmacies that contract with Caremark) have agreed to accept as payment in full, when we pay primary benefits.

Our PPO allowance includes any known discounts that can be accurately calculated at the time your claim is processed. For PPO facilities, we sometimes refer to our allowance as the "Preferred rate." The Preferred rate may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf. (See page 97 for special information about limits on the amounts Preferred dentists can charge you under Standard Option.)

- **Participating providers -** Our allowance (which we may refer to as the "PAR" for "Participating Provider Allowance") is the negotiated amount that these providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with some local Blue Cross and Blue Shield Plans) have agreed to accept as payment in full, when we pay primary benefits. For facilities, we sometimes refer to our allowance as the "Member rate." The member rate includes any known discounts that can be accurately calculated at the time your claim is processed, and may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf.
- **Non-participating providers -** We have no agreements with these providers. We determine our allowance as follows:
  - For inpatient services at hospitals, and other facilities that do not contract with your local Blue Cross and Blue Shield Plan (“Non-member facilities”), our allowance is based on the average amount paid nationally on a per day basis to contracting and non-contracting facilities for covered room, board, and ancillary charges for your type of admission. If you would like additional information, or to obtain the current allowed amount, please call the customer service number on the back of your ID card. For inpatient stays resulting from medical emergencies or accidental injuries, or for routine deliveries, our allowance is the billed amount;
  - For outpatient, non-emergency surgical services at hospitals and other facilities that do not contract with your local Blue Cross and Blue Shield Plan (“Non-member facilities”), our allowance is the average amount for all outpatient surgical claims that we pay nationally to contracting and non-contracting facilities. If you would like additional information, or to obtain the current allowed amount, please call the customer service number on the back of your ID card. For other outpatient services by Non-member facilities, and for outpatient surgical services resulting from a medical emergency or accidental injury, our allowance is the billed amount (minus any amounts for noncovered services);

- For physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount) or 2) 100% of the 2009 Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained. Local Plans determine the UCR amount in different ways. Contact your Local Plan if you need more information. We may refer to our allowance for Non-participating providers as the "NPA" (for "Non-participating Provider Allowance");
- For prescription drugs furnished by retail and internet pharmacies that do not contract with Caremark, our allowance is the average wholesale price ("AWP") of a drug on the date it is dispensed, as set forth in the most current version of First DataBank's National Drug Data File; and
- For services you receive outside of the United States and Puerto Rico from providers that do not contract with us or with Mondial Assistance, our allowance is an Overseas Fee Schedule that is based on amounts comparable to what Participating providers in the Washington, DC, area have agreed to accept.

Non-participating providers are under no obligation to accept our allowance as payment in full. If you use Non-participating providers, you will be responsible for any difference between our payment and the billed amount (except in certain circumstances – see below). In addition, you will be responsible for any applicable deductible, coinsurance, or copayment amounts.

Note: For **certain** covered services from Non-participating professional providers, your responsibility for the difference between the Non-participating Provider Allowance (NPA) and the billed amount may be limited.

In **only** those situations listed below, when the difference between the NPA and the billed amount for covered Non-participating professional care is greater than $5,000 for an episode of care, your responsibility will be limited to $5,000 (in addition to any applicable deductible, coinsurance, or copayment amounts). An episode of care is defined as all covered Non-participating professional services you receive duringan emergency room visit, an outpatient visit, or a hospital admission (including associated emergency room or pre-admission services),plus your first follow-up outpatient visit to the Non-participating professional provider(s) who performed the service(s) during your hospital admission or emergency room visit.

- When you receive care in a Preferred hospital from Non-participating professional providers such as aradiologist, anesthesiologist, certified registered nurse anesthetist (CRNA), pathologist, neonatologist, orpediatric sub-specialist;and the professional providers are hospital-based or are specialists recruited from outside the hospital either without your knowledge and/or because they are needed to provide immediate medical or surgical expertise; and
- When you receive care from Non-participating professional providersin a Preferred, Member, or Non-member hospital as a result of a medical emergency or accidental injury (see pages 77 and 79).

For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see pages 21, 104, and 105.

Precertification

The requirement to contact the local Blue Cross and Blue Shield Plan serving the area where the services will be performed before being admitted to the hospital for inpatient care, or within two business days following an emergency admission.

Preferred provider organization (PPO) arrangement

An arrangement between Local Plans and physicians, hospitals, health care institutions, and other covered health care professionals (or for retail and internet pharmacies, between pharmacies and Caremark) to provide services to you at a reduced cost. The PPO provides you with an opportunity to reduce your out-of-pocket expenses for care by selecting your facilities and providers from among a specific group. PPO providers are available in most locations; using them whenever possible helps contain health care costs and reduces your out-of-pocket costs. The selection of PPO providers is solely the Local Plan's (or for pharmacies, Caremark's) responsibility. We cannot guarantee that any specific provider will continue to participate in these PPO arrangements.

Prior approval

Written assurance that benefits will be provided by:

1. The Local Plan where the services will be performed;
2. The Retail Pharmacy Program (for prescription drugs and supplies purchased through Preferred retail and internet pharmacies) or the Mail Service Prescription Drug Program; or
3. The Blue Cross and Blue Shield Association Clinical Trials Information Unit for certain organ/tissue transplants we cover only in clinical trials. See Section 5(b).

For more information, see the benefit descriptions in Section 5 and *How to get approval for . . . Other services* on pages 16-17. See Section 5(e) for special authorization requirements for mental health and substance abuse benefits.

Routine services

Services that are not related to a specific illness, injury, set of symptoms, or maternity care.

Sound natural tooth

A tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.

Transplant period

A defined number of consecutive days associated with a covered organ/tissue transplant procedure.

Us/We/Our

"Us," "we," and "our" refer to the Blue Cross and Blue Shield Service Benefit Plan, and the local Blue Cross and Blue Shield Plans that administer it.

You/Your

"You" and "your" refer to the enrollee (the contract holder eligible for enrollment and coverage under the Federal Employees Health Benefits Program and enrolled in the Plan) and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/insure/health for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies who participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you a *Guide toFederal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment;
  - How you can cover your family members;
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
  - What happens when your enrollment ends; and
  - When the next Open Season for enrollment begins.

  We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

  Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

  If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Children's Equity Act**

  OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2009 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2008 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage, or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide toFederal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

  If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

  You may not elect TCC if you are fired from your Federal job due to gross misconduct.

  Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide toFederal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

  You may convert to a non-FEHB individual policy if:

  - Your coverage under TCC or the spouse equity law ends (if you canceled your coverage or did not pay your premium, you cannot convert);
  - You decided not to receive coverage under TCC or the spouse equity law; or
  - You are not eligible for coverage under TCC or the spouse equity law.

  If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

  Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

  The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health-related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

  For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; and refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA. .

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants, and X-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period.

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames, and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear. This Index is not an official statement of benefits.

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2009

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the $300 per person ($600 per family) calendar year deductible. If you use a Non-PPO physician or other health care professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: 15%* of our allowance; $20 per office visit Non-PPO: 30%* of our allowance	29-31
Services provided by a hospital:		
• Inpatient	PPO: $200 per admission Non-PPO: $300 per admission	66-68
• Outpatient	PPO: 15%* of our allowance (no deductible for surgery) Non-PPO: 30%* of our allowance (no deductible for surgery)	69-71
Emergency benefits:		
• Accidental injury	PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: Any difference between our payment and the billed amount within 72 hours; regular benefits thereafter Ambulance transport services: Nothing	76-78
• Medical emergency	Regular benefits for physician and hospital care* Ambulance transport services: $100 per day for ground ambulance (no deductible); $150 per day for air or sea ambulance (no deductible)	76, 79-80
Mental health and substance abuse treatment	In-Network (PPO): Regular cost-sharing, such as $20 office visit copay (prior approval required); $200 per inpatient admission Out-of-Network (Non-PPO): Benefits are limited	81-87
Prescription drugs	Retail Pharmacy Program: • PPO: 20% of our allowance generic/30% of our allowance brand-name; up to a 90-day supply • Non-PPO: 45% of our allowance (AWP); up to a 90-day supply Mail Service Prescription Drug Program:	88-95

	• $10 generic/$65 brand-name per prescription; up to a 90-day supply	
Dental care	Scheduled allowances for diagnostic and preventive services, fillings, and extractions; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	55, 96--100
Special features:	**Special features:** Flexible benefits option; online customer and claims service; Blue Health Connection; services for deaf and hearing impaired; Web accessibility for the visually impaired; travel benefit/services overseas; health support programs; Healthy Families Program; and *WalkingWorks®* Wellness Program	102-103
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after $5,000 (PPO) or $7,000 (PPO/Non-PPO) per contract per year; some costs do not count toward this protection	21-22

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2009

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Basic Option does not provide benefits when you use Non-preferred providers. For a list of the exceptions to this requirement, see page 14. There is no deductible for Basic Option.

Basic Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: $25 per office visit for primary care physicians and other health care professionals; $30 per office visit for specialists Non-PPO: You pay all charges	29-31
Services provided by a hospital:		
• Inpatient	PPO: $100 per day up to $500 per admission Non-PPO: You pay all charges	66-68
• Outpatient	PPO: $50 per day per facility Non-PPO: You pay all charges	69-71
Emergency benefits:		
• Accidental injury	PPO: $75 copayment for emergency room care; $30 copayment for urgent care Non-PPO: $75 copayment for emergency room care Ambulance transport services: $100 per day for ground ambulance; $150 per day for air or sea ambulance	76-78
• Medical emergency	Same as for accidental injury	76, 79-80
Mental health and substance abuse treatment	In-Network (PPO): Regular cost sharing, such as $25 office visit copayment (prior approval required); $100 per day up to $500 per inpatient admission Out-of-Network (Non-PPO): You pay all charges	81-87
Prescription drugs:	Retail Pharmacy Program: • PPO: $10 generic/$35 formulary brand-name per prescription/50% coinsurance ($45 minimum) for non-formulary brand-name drugs. 34-day maximum supply on initial prescription; up to 90 days for refills with 3 copayments • Non-PPO: You pay all charges	88-95

Basic Option Benefits	You pay	Page
Dental care	PPO: $20 copayment per evaluation (exam, cleaning, and X-rays); most services limited to 2 per year; sealants for children up to age 16; $25 copayment for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	55, 96-97, 101
Special features:	**Special features:** Flexible benefits option; online customer and claims service; Blue Health Connection; services for deaf and hearing impaired; Web accessibility for the visually impaired; travel benefit/services overseas; health support programs; Healthy Families Program; and *WalkingWorks®* Wellness Program	102-103
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000 (PPO) per contract per year; some costs do not count toward this protection	21-22

2009 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the *Guide to Benefits for Career United States Postal Service Employees*, RI 70-2, and to the rates shown below.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees, and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *Guide to Federal Benefits*.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Standard Option Self Only	104	$155.66	$70.18	$337.26	$152.06	$179.45	$46.39
Standard Option Self and Family	105	$352.56	$164.58	$763.88	$356.59	$406.42	$110.72
Basic Option Self Only	111	$128.00	$42.66	$277.32	$92.44	$147.62	$23.04
Basic Option Self and Family	112	$299.75	$99.91	$649.45	$216.48	$345.71	$53.95