

Enclosure 2A - Fee-for-Service brochure examples

This is the key for the "Print size" and "Print style". Follow the visual in making text: **bold**, ***bold-italicized***, and *italicized*, and for shading degrees.

- ① Times New Roman, 32-point
- ② Times New Roman, 14-point
- ③ Times New Roman, 16-point
- ④ Times New Roman, 13-point
- ⑤ Times New Roman, 10 point
- ⑥ {{Use Graphic for logo AND its text}}
- ⑦ Times New Roman, 11-point
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- ⑨ Tahoma, 14-point (or equivalent)

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FFS Plan name

http://www.planAddress.org

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A fee-for-service plan with a preferred provider organization

Sponsored and administered by: {insert sponsoring organization name}

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Who may enroll in this Plan: {plan specific}

To become a member or associate member: {plan specific}

XXXXXX
XXXXXX

If you are a non-postal employee/annuitant, you will automatically become an associate member of {organization name} upon enrollment in the {Plan name}.

Annuitants (retirees) may {may not} enroll in this Plan. {plan specific}

Membership dues: \$xx per year for an associate membership. {Organization name} will bill new associate members for the annual dues when it receives notice of enrollment. {Organization name} will also bill continuing associate members for the annual membership. Active and retired Postal Service employee's membership dues vary by {organization} local. {Plan specific}

Enrollment codes for this Plan:

- 001 High Option - Self Only
- 002 High Option - Self and Family
- 004 Standard Option - Self Only
- 005 Standard Option - Self and Family

Add logo for any accreditation you have and say below it:

This Plan has _____ accreditation from the _____. See the 2002 Guide for more information on accreditation. {RV: 6-1}

Authorized for distribution by the:

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United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

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5 RI 71-xxx

2 Table of Contents

5 Introduction.....	XX
Plain Language.....	XX
Inspector General Advisory.....	XX
Section 1. Facts about this fee-for-service plan.....	XX
Section 2. How we change for 2002.....	XX
Section 3. How you get care	XX
Identification cards	XX
Where you get covered care	XX
• Covered providers	XX
• Covered facilities.....	XX
What you must do to get covered care.....	XX
How to get approval for... ..	XX
• Your hospital stay (precertification).....	XX
• Other services	XX
Section 4. Your costs for covered services.....	XX
• Copayments	XX
• Deductible	XX
• Coinsurance	XX
• Differences between our allowance and the bill	XX
Your out-of-pocket maximum	XX
When government facilities bill us... ..	XX
If we overpay you.....	XX
When you are age 65 or over and you do not have Medicare	XX
When you have Medicare	XX
Section 5. Benefits	XX
Overview	XX
(a) Medical services and supplies provided by physicians and other health care professionals	XX
(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	XX
(c) Services provided by a hospital or other facility, and ambulance services.....	XX
(d) Emergency services/accidents	XX
(e) Mental health and substance abuse benefits	XX
(f) Prescription drug benefits.....	XX
(g) Special features.....	XX
• Flexible benefits option	
• <i>{bullet list your other features}</i>	

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(h) Dental benefits <i>{do not remove this--in benefit section show "no benefit" if you don't have dental}</i> xx	
(i) Point of Service Product <i>{remove this & renumber next if you don't have POS benefits}</i>	xx
(j) Non-FEHB benefits available to Plan members <i>{remove this if you don't have non-FEHB benefits}</i> xx	
5 Section 6. General exclusions -- things we don't cover	xx
Section 7. Filing a claim for covered services	xx
Section 8. The disputed claims process	xx
Section 9. Coordinating benefits with other coverage	xx
When you have other health coverage	xx
Original Medicare	xx
Medicare managed care plan	xx
TRICARE/Workers Compensation/Medicaid	xx
When other Government agencies are responsible for your care.....	xx
When others are responsible for injuries.....	xx
Section 10. Definitions of terms we use in this brochure	xx
Section 11. FEHB facts	xx
Coverage information	xx
• No pre-existing condition limitation.....	xx
• Where you get information about enrolling in the FEHB Program.....	xx
• Types of coverage available for you and your family	xx
• When benefits and premiums start	xx
• Your medical and claims records are confidential.....	xx
• When you retire	xx
When you lose benefits.....	xx
• When FEHB coverage ends.....	xx
• Spouse equity coverage	xx
• Temporary Continuation of Coverage (TCC).....	xx
• Enrolling in TCC	xx
• Converting to individual coverage.....	xx
• Getting a Certificate of Group Health Plan Coverage	xx
Long term care insurance is coming later in 2002	xx
Department of Defense/FEHB Program Demonstration Project <i>{delete if you are not a DoD demo project plan}</i> ..	xx
INDEX	xx
Summary of Standard Option benefits.....	xx
Summary of High Option benefits.....	xx
Rates.....	Back cover

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② Section 2. How we change for 2002

Do not rely on these change descriptions; this page 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. *{Plan - add from below all that apply, along with your changes.}*

⑤ Program-wide changes

- We added a new Section after Section 11 to discuss the Long Term Care Insurance Program that is coming in 2002.
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover routine screening for chlamydial infection. (Section 5(a))
- We increased speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- We clarified the brochure to show why we think you should use generic drugs whenever possible. We move other language around within the Prescription drugs section but didn't change its meaning. (Section 5(f))
- We changed the address for sending disputed claims to OPM. (Section 8)
- We clarified the Medicare Primary Payer Chart to explain how we coordinate benefits for former spouses. (Section 9)
- We clarified other language about coordinating benefits with Medicare. (Section 9)

Changes to this Plan

- Your share of the non-Postal premium will [decrease][increase] by xx% for Self Only or xx% for Self and Family.
- We added a logo from an accrediting organization to our brochure cover because we are accredited by.....
- We clarified the brochure to better explain that the non-PPO benefits are the standard benefits of this Plan, that PPO benefits apply only when you use a PPO provider, and that when no PPO provider is available, non-PPO benefits apply.
- We clarified the Preventive care, adult benefits by removing the entry for blood lead level testing for adults because it is a test more typically done for children. (Section 5(a))
- We clarified the Family planning and Infertility benefits by providing more examples of covered and not covered benefits. (Section 5(a))
- We clarified Surgical procedures to show that we cover a comprehensive range of services, such as operative procedures. (Section 5(b))

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EXAMPLES

Section 3. How you get care

⑧ Identification cards

⑤ We will send you an identification (ID) card. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your 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 us at xxx-xxx-xxxx.

Where you get covered care

You can get care from any “covered provider” or “covered facility.” How much we pay – and you pay – depends on the type of covered provider or facility you use. If you use our preferred providers, or our point-of-service program, you will pay less.

⑤ • Covered providers

We consider the following to be covered providers when they perform services within the scope of their license or certification: *{Insert your list}*

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved." For 2002, the states are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, South Carolina, South Dakota, Utah, and Wyoming. *{Reminder: These providers must now include pastoral counselors--see Carrier Letter 2000-45}*

• Covered facilities

Covered facilities include: *{Plan specific list moved here from 2000 brochure's Definitions}*

- Hospital
- xxxxxxx

What you must do to get covered care

It depends on the kind of care you want to receive. You can go to any provider you want, but we must approve some care in advance.

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 PPO specialist because we terminate our contract with your specialist for other than cause,
- you may be able to continue seeing your specialist and receiving any PPO 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

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

5 Under the FEHB law, we must limit our payments for those benefits you would be entitled to if you had Medicare. And, your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. The following chart has more information about the limits.

8 If you...

- **5** 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.)

8 Then, for your inpatient hospital care,

- **5** 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 applicable deductibles, coinsurance, or copayments you owe 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 Medicare equivalent amount.

8 And, for your physician care, 5 the law requires us to base our payment and your coinsurance 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 a member of our PPO network,	your deductibles, coinsurance, and copayments;
Participates with Medicare and is not in our PPO network,	your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount;
Does not participate with Medicare,	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount

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.

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.

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② Section 5. Benefits -- OVERVIEW

⑧ (See page xx for how our benefits changed this year and page xx for a benefits summary.)

⑤ NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at {phone number} or at our website at www.{insert web address}.

- (a) Medical services and supplies provided by physicians and other health care professionalsxx-xx
{page numbers of section}
- Diagnostic and treatment services
 - Lab, X-ray, and other diagnostic tests
 - Preventive care, adult
 - Preventive care, children
 - Maternity care
 - Family planning
 - Infertility services
 - Allergy care
 - Treatment therapies
 - Physical and occupational therapy
 - Speech therapy
 - Speech therapy
 - Hearing services (testing, treatment, and supplies)
 - Vision services (testing, treatment, and supplies)
 - Foot care
 - Orthopedic and prosthetic devices
 - Durable medical equipment (DME)
 - Home health services
 - Chiropractic
 - Alternative treatments
 - Educational classes and programs
- (b) Surgical and anesthesia services provided by physicians and other health care professionals..... xx-xx
- Surgical procedures
 - Reconstructive surgery
 - Organ/tissue transplants
 - Anesthesia
 - Oral and maxillofacial surgery
- (c) Services provided by a hospital or other facility, and ambulance services xx-xx
- Inpatient hospital
 - Outpatient hospital or ambulatory surgical center
 - Extended care benefits/Skilled nursing care facility benefits
 - Hospice care
 - Ambulance
- (d) Emergency services/Accidents..... xx-xx
- Medical emergency
 - Accidental injury
 - Ambulance
- (e) Mental health and substance abuse benefits xx-xx
- (f) Prescription drug benefits..... xx-xx
- (g) Special features xx-xx
- Flexible benefits option
 - {bullet list your features}
- (h) Dental benefits {do not remove this--in benefit section show "no benefit" if you don't have dental}..... xx-xx
- (i) Point of Service benefits {remove this & renumber next, if you don't have POS benefits} xx-xx
- (j) Non-FEHB benefits available to Plan members {remove this if you don't have non-FEHB benefits} xx-xx
- SUMMARY OF BENEFITS xx{page # from summary at back of brochure}

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EXAMPLES

② Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

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Here are some important things you should keep in mind about these benefits:

- **5** 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.
- **5** The calendar year deductible is: \$275 per person (\$550 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. *{If you want, you can say, "We added asterisks - * - to show when the calendar year deductible does not apply."}*
- **5** The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- 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 with Medicare.

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⑧ Benefit Description	⑧ You pay
5 NOTE: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.	
8 Diagnostic and treatment services	
5 Professional services of physicians <ul style="list-style-type: none"> • In physician’s office 	PPO: \$15 copayment (deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

2Section 6. General exclusions – things we don't cover

5 The exclusions in this section apply to all benefits. **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.**

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;
- Experimental or investigational procedures, treatments, drugs or devices;
- 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 *{plan specific—can vary somewhat; discuss with contracts specialist }*;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

{{Insert other “General Exclusions” that apply—your contract specialist will help you edit for plain language and necessity – BE SURE TO PUT “; or” after the next to last entry and then a period after the last entry}}

②Section 7. Filing a claim for covered services

⑧How to claim benefits

⑤To obtain claim forms or other claims filing advice or answers about our benefits, contact us at _____, or at our website at www.xxx.

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at xxx.

When you must file a claim -- such as for overseas claims or when another group health plan is primary -- submit it on the HCFA-1500 or a claim form that includes the information shown below. 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, or balance due statements are not acceptable substitutes for itemized bills.

In addition:

- You must send a copy of the explanation of benefits (EOB) 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; private duty nursing; 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 ordered through the Mail Service Prescription Drug Program must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date, and charge.

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Section 8. The disputed claims process

{NOTE: For step numbers below, sample below is 16pt Tahoma. But as long as the numbers stand out and look balanced, it won't matter what type face you use.}

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 preauthorization/prior approval:

Step	Description
91	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"> (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: <i>{{Plan address}}</i>; 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.
92	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"> (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); 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	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"> • 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. <p>Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division x, 1900 E Street, NW, Washington, DC 20415-xxxx. <i>{PO Box being discontinued. Now use zip+4 extensions. Use: Division 1...20415-3610 or Division 2...20415-3620 or Division 3...20415-3630}</i></p>