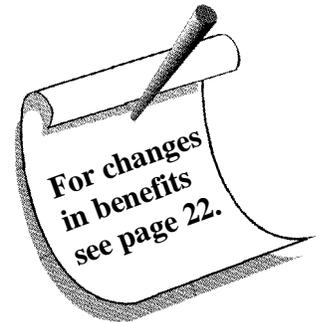

A Health Maintenance Organization



Serving: The greater Longview, **Washington** area; and the greater Eugene/Springfield, Albany/Corvallis, Roseburg, and Reedsport, **Oregon** areas.

You must live in the service area described on page 8 to enroll in this Plan.

Enrollment code:
SD1 Self Only
SD2 Self and Family

Service Area: Services from Plan providers are available only in the area described on page 8.

Authorized for distribution by the:



**United States
Office of
Personnel
Management**



RI 73-083

SelectCare®

SelectCare Health Plans, 600 Country Club Road, Eugene, Oregon 97401, has entered into a contract (CS 1910) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called SelectCare®, or the Plan.

This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. A person enrolled in the Plan is entitled to the benefits stated in this brochure. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1998, and are shown on the inside back cover of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your Plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation — sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Plan at 800/248-2330- ext. 3044 and explain the situation.
- If the matter is not resolved after speaking to your Plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on page 14. If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See “If you are hospitalized” on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program

General Information *continued*

If you are hospitalized when you change plans

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in the Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions, including divorces, of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

General Information *continued*

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits, and if so, what you will have to pay.

You may also remain enrolled in the Plan when you join a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. See page 19 for information on the Medicare prepaid plan offered by this Plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

General Information *continued*

Notification and election requirements

Separating employees — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Children — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

Former spouses — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available — or chosen — when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Facts about this Plan

This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO). When you enroll in an HMO, you are joining an organized system of health care that arranges in advance with specific providers and hospitals to give care to members and pays them directly for their services. Covered services are available only from Plan providers except during a medical emergency or when there has been prior authorization. Members are required to select a personal care doctor from participating Plan primary care doctors. Services of a specialty care doctor can only be received by referral from the selected primary care doctor except as otherwise specified in this brochure. There are no claim forms when Plan doctors are used.

Your decision to join an HMO should be based on your preference for the Plan's benefits and delivery system, not because a particular provider is on the Plan's network. You cannot change Plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

Who provides care to Plan members?

SelectCare® is a mixed model plan that contracts with doctors and specialists who practice out of their own offices, and hospitals, to provide care to members. Each individual family member may choose their own primary care doctor.

Role of a primary care doctor

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when you have been referred by your primary care doctor, with the following exceptions: a woman's annual gynecological exam; routine maternity care; family planning services; routine vision examinations for children under age 18; and mental health and chemical dependency services. All members must contact the Plan's authorizing agent to obtain services for treatment of mental conditions or substance abuse (chemical dependency) rather than the member's primary care doctor. The authorizing agents are listed in the provider directory or call the Plan's Mental Health Team at 1-800/248-2330 ext. 3013. Women may see any participating Women's Health Care Provider for their annual gynecological exam, maternity care, and family planning services.

Choosing your doctor

The Plan's provider directory lists primary care doctor's (generally family practitioners, pediatricians, and internists) with their locations and phone numbers and notes whether or not the doctor is accepting new patients. Directories are updated twice a year and are available at the time of enrollment or upon request by calling the Customer Service Representative, 541/485-2145 (or outside local call area 1-800/248-2330); you can also find out if your doctor participates with this Plan by calling these numbers. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important Note: When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.

If you enroll, you will be asked to let the Plan know which primary care doctor you've selected for you and each member of your family by sending a selection form to the Plan. Members may change their doctor selection by completing a Change of Physician form or by calling the Plan. The change will be effective upon receipt of the form by SelectCare®.

If you are receiving services from a doctor who leaves the Plan, the Plan will notify you in writing and will immediately reassign you to a new primary care doctor. If you want to change to another primary care doctor, call the Plan or follow the instructions outlined in the letter.

Referrals for specialty care

Except in a medical emergency, as otherwise stated in this brochure, or when a primary care doctor has designated another doctor to see his or her patients, you must receive a referral from your primary care doctor before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the discretion of the primary care doctor subject to the approval of your PCP's Managed Care Committee; if non-Plan specialists or consultants are required, your primary care doctor will arrange appropriate referrals and authorizations.

When you receive a referral from your primary care doctor, you must return to your primary care doctor after the consultation. All follow-up care must be provided or authorized by the primary care provider. Referrals from the primary care doctor will give specific instructions to the consultant as to what services are authorized. If additional services or visits are suggested by the consultant, you must first check with your primary care doctor. Do not go to the specialist unless your primary care doctor has arranged for the referral in advance, including follow-up visits.

Facts about this Plan *continued*

Authorizations

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose, or treat your illness or condition.

Certain services, such as use of non-participating specialists or private duty nursing, require prior authorization from the Plan. Your primary care doctor must obtain authorization from the Plan, prior to services being performed.

For new members

If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral from your primary care doctor for the care of the specialist to be covered by the Plan. If the doctor who originally referred you is now your Plan primary care doctor, you need only call to explain that you are now a Plan member and ask that you be referred prior to your next appointment with the specialist.

If you are selecting a new primary care doctor and want to continue with this specialist, you must schedule an appointment so that the primary care doctor can decide whether to treat the condition directly or refer you back to the specialist.

Hospital care

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

Out-of-pocket maximum

Copayments are required for a few benefits. However, copayments will not be required for the remainder of the calendar year after your out-of-pocket expenses for covered services reach \$500 per Self Only enrollment or \$1,500 per Self and Family enrollment. This copayment maximum does not include costs of prescription drugs, non-covered services, or amounts that exceed the Plan's allowances.

You should maintain accurate records of the copayments made, as it is your responsibility to determine when the copayment maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments are due when service is rendered, except for emergency care.

Deductible carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

The Plan's Service Area

The service area for this Plan, where Plan providers and facilities are located, includes the following areas:

In Oregon - Benton, Clatsop, Columbia, Coos, Douglas, Lane, Linn, Marion and Polk Counties

In Washington - Cowlitz and Wahkiakum Counties and the portion of Pacific County defined by zip codes 98614, 98624, 98631, 98637, 98638, 98640, 98641, 98644, and the portion of Lewis County defined by zip codes 98591, 98593, and 98596.

You must live or work in the Service Area to enroll in this Plan.

Benefits for care outside the service area are restricted to emergency services, as described on page 14, except as described in the next paragraph.

Eligible dependent children who are away at school or reside outside the Plan's service area can receive benefits for other than emergency services after arrangements are made with the Plan. Covered services will be paid at the lesser of the stated in-area benefit or 80% of usual, customary and reasonable charges (UCR). Designation of a primary care doctor is not required. Some services require prior authorization. Call the Plan for more information.

If you or a covered family member move outside the Service Area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan. This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, benefits will be coordinated with Medicare according to Medicare's determination of which coverage is primary. Generally, you do not need to take any action after informing the Plan of your or your family member's eligibility for Medicare. Your Plan will provide you with further instructions if a Medicare claim needs to be filed.

Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid

General Limitations *continued*

Medicaid

plan, special limitations on your CHAMPUS coverage apply; your primary provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

Workers' compensation

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

DVA facilities, DoD facilities, and Indian Health Service

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers' Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

Other Government agencies

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Liability insurance and third party actions

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

If a covered person is sick or injured as a result of the act or omission of another person or party, the

General Exclusions

~~Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need information about subrogation, the Plan will provide you with its subrogation procedures.~~

All benefits are subject to the limitations and exclusions in this brochure. Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition as discussed under "Authorizations" on page 8. The following are excluded: The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see Emergency Benefits)
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program
- Services not required according to accepted standards of medical, dental, or psychiatric practice
- Procedures, treatments, drugs or devices that are experimental or investigational
- Procedures, services, drugs, and supplies related to sex transformations; and

Medical and Surgical Benefits

What is 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.

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; you pay a \$5 office visit copay, but no additional copay for laboratory tests and X-rays. Within the Service Area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate; you pay a \$5 copay for a house call.

The following services are included and are subject to the office visit copay unless stated otherwise:

- Preventive care, including well-baby care and periodic check-ups per age schedule: under 1 year, as recommended by the primary care doctor; 1 to 2 years, one visit every three months; 3 to 11 years, as recommended by the primary care doctor; 12 to 17 years, one visit every 3 years; 18 to 39 years, one visit every 5 years; 40 and older as recommended by the primary care doctor.
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years or as recommended by provider. In addition to routine screening, mammograms are covered when prescribed by the provider as medically necessary to diagnose or treat your illness; you pay nothing.
- Routine immunizations and boosters; you pay nothing.
- Gynecological exams once every 12 months or more frequently if designated high risk
- Consultations by specialists
- Surgery in a doctor's office; you pay \$5 per visit
- Diagnostic procedures, such as laboratory tests and X-rays; you pay nothing.
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor (office visit copays are waived for obstetrical care). The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Hearing tests and vision screening for children under age 18 once every 24 months
- Allergy testing and treatment, including test and treatment materials (such as allergy serum); you pay a \$5 copay per allergy injection
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints
- Cornea, heart, heart/lung, lung (single or double); kidney, and liver transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's Lymphoma; advanced neuroblastoma; large cell lymphoma; Burkitts lymphoma; testicular, mediastinal, retroperitoneal and ovarian germ cell tumors; breast cancer; multiple myeloma; and epithelial ovarian cancer. Transplants are covered when approved by the Plan. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan. Transportation and living expenses of the donor and member are covered up to \$250 per day to a maximum of \$20,000.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure; you pay nothing.
- Dialysis; you pay nothing.
- Chemotherapy, radiation therapy and inhalation therapy; you pay nothing.
- Surgical treatment of morbid obesity
- Prosthetic devices, such as artificial limbs (limited to first device), you pay 20% of charges. External or internal lenses following cataract removal; you pay nothing.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Medical and Surgical Benefits *continued*

Limited benefits

- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need (copayment waived)
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers (copayment waived)
- Primary care physician visits for tobacco addiction services including examinations, discussion of treatment options, and prescriptions for covered nicotine deterrent medication.

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or areas surrounding the teeth, are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient and outpatient basis for up to two consecutive months per condition if significant improvement can be expected within two months. Inpatient treatment for cerebral vascular accidents, burns, fractures or related conditions are not limited to the short term rehabilitation benefit limits. Inpatient rehabilitation; you pay nothing. Outpatient therapy; you pay \$5 per session. Speech therapy is limited to treatment for certain impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Diagnosis and treatment of infertility is covered; you pay \$5 per office visit. The following types of artificial insemination are covered: intracervical insemination (ICI) and intrauterine insemination (IUI); you pay \$5 per office visit; cost of donor sperm is not covered. Fertility drugs are covered under Prescription Drug Benefits. Other assisted reproductive technology (ART) procedures such as in vitro fertilization and embryo transfer, are not covered.

Cardiac rehabilitation for symptomatic heart disease as evidenced by a heart transplant, bypass surgery, a myocardial infarction, angina pectoris, congestive heart failure or percutaneous transluminal coronary angioplasty is provided once per lifetime when authorized by the Plan doctor and SelectCare. You pay nothing, but you must complete Phase II in order to receive benefits.

Diabetes self-management training for initial outpatient education is covered up to a maximum Plan payment of \$500. Prior Plan authorization is required.

Home oxygen unit rental is covered for significant hypoxemia; you pay 20% of charges

Orthopedic devices, e.g., braces, are covered; prior Plan authorization is required if cost exceeds \$500.

Ostomy supplies and diabetic supplies including needles, syringes and chem strips are covered; you pay 20% of charges.

Durable medical equipment, such as wheelchairs, hospital beds, and reasonable repair costs are covered. You pay 20% of charges for rental not to exceed the purchase price.

Orthotic devices are covered including fitting and follow up exam as required as a result of surgery, congenital defect or diabetes. You pay 20% of charges. The benefit is limited to two pair every two years and a maximum benefit of \$200 in two years.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel.
- Transplants not listed as covered
- Reversal of voluntary, surgically-induced sterility
- Plastic surgery primarily for cosmetic purposes
- Hearing aids
- Homemaker services

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

- Chiropractic services

Hospital/Extended Care Benefits

What is covered

Hospital care

- Long-term rehabilitation therapy

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. You pay nothing. All necessary services are covered, including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care

Extended care

- Specialized care units, such as intensive care or cardiac care units

The Plan provides a comprehensive range of benefits for up to 60 days per illness or injury when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. You pay nothing. All necessary services are covered, including:

- Bed, board and general nursing care
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months. Sixty day limit applicable to extended care does not apply.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor. You pay \$25 copay per trip.

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 16 for non-medical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television

Emergency Benefits

What is a medical emergency?

- Custodial care, rest cures, domiciliary or convalescent care

A medical emergency is the sudden and unexpected onset of a condition or an injury that 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 the Plan may determine are medical emergencies — what they all have in common is the need for quick action.

Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours unless it is not reasonably possible to do so. It is your responsibility to ensure that the Plan is notified in a timely manner. If you are hospitalized in non-Plan facilities, services will be limited to the first 24 hours following injury or the onset of illness or until the member can be safely transferred to the care of a participating doctor and hospital. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized in a non-Plan facility, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and a Plan doctor believes care can be provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

Plan pays . . .

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan.

You pay . . .

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

The lesser of 50% of the emergency room charges or \$50 per hospital emergency room visit; or \$5 per urgent care center or for care in a physician's office for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, directly from the emergency room, the emergency room and ambulance copays are waived.

Emergencies outside the service area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Plan pays . . .

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by your primary care doctor.

You pay . . .

Reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers.

The lesser of 50% of the emergency room charges or \$50 per hospital emergency room visit; or \$5

Emergency Benefits *continued*

What is covered

per urgent care center visit or for care in a physician's office for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital directly from the emergency room, the emergency room and ambulance copays are waived.

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan. You pay \$25 copay per trip. If the emergency results in admission to a hospital directly from the emergency room, the ambulance copay is waived.

What is not covered

- Elective care or nonemergency care
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area
- Medical and hospital costs resulting from a normal full-term delivery (after the 36th week of pregnancy) of a baby outside the service area

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

and the provisions of the contract on which the denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 20.

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care

All members must contact the Plan's authorizing agent, not their primary care doctor, to obtain services. Members may refer to the Plan's Provider Directory for information about the authorizing agent or call the Plan's Mental Health Team at 1-800/248-2330, ext. 3013.

Inpatient care

Up to 20 outpatient visits to Plan providers each calendar year; you pay \$15 for each covered visit—all charges thereafter.

What is not covered

Up to 30 days of hospitalization each calendar year; you pay a \$50 copay per day for first 30 days — all charges thereafter.

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

Substance abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition and, to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient care

All members must contact the Plan's authorizing agent not their primary care doctor, to obtain services. Members may refer to the Plan's Provider Directory for information about the authorizing agent or call the Plan's Mental Health Team at 1-800/248-2330 ext. 3013.

Up to 20 outpatient visits to Plan providers or Plan payment of \$750 for adults and \$1,000 for children under age 18, whichever is greater, per calendar year; you pay \$15 per visit — all charges after \$750 or \$1,000 benefit maximum.

Inpatient care

The substance abuse benefit may be combined with the outpatient mental conditions benefit shown above, provided such treatment is necessary and approved by the Plan, to permit an additional 20 outpatient visits per calendar year with the applicable mental conditions benefit copayments.

Plan pays up to \$4,500 for adults and \$4,000 for children under 18 in any 24-consecutive-month period in an alcohol detoxification or rehabilitation center approved by the Plan. Plan pays up to \$3,500 for resident care for adults or \$3,000 for children in any 24-consecutive-month period; you pay nothing. For children, there is an additional \$1,500 floating benefit which may be used for either inpatient or residential care.

What is not covered

Prescription Drug Benefits

What is covered

- Treatment that is not authorized by a Plan doctor.

Prescription drugs prescribed by a Plan or referral doctor and obtained at any licensed pharmacy in the U.S. will be dispensed for up to a 34-day supply or a one month supply of insulin.

There are three ways you can have your prescription or refills filled; the choice is yours each time you need medication.

- Participating pharmacies — When you use a participating pharmacy, you pay a \$5 copay for each prescription or refill for generic drugs or a \$10 copay for name brand drugs when generic substitution is not available. When generic substitution is available (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, you pay the price difference between the generic and name brand drug as well as the \$10 copay per prescription unit or refill. There are no claim forms or deductibles.
- Nonparticipating pharmacies — You may use any licensed pharmacy in the United States. You are responsible for the full payment of the prescription or refill at the time of purchase. Submit the prescription drug receipt along with a completed claim form to the Plan. There is a \$50 deductible per person, per year. After you have met the deductible (paid \$50 in covered prescription expenses), you will be reimbursed up to 80%, unless otherwise stated in this brochure, of covered charges. After three family members have each satisfied a deductible, all family members' prescriptions thereafter will be reimbursed at 80% for the remainder of that calendar year.
- Mail order pharmacy service — You may order up to a 90-day supply of your maintenance medication by completing a Certifax mail order form; enclose a \$5 copay for generic drugs or a \$10 copay for brand name drugs and mail the order form and copayment to Certifax. You may call Certifax, toll-free, at 800/635-3070. You will receive additional information on this service. The prescription deductible does not apply.

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Non-formulary drugs will be covered when prescribed by a Plan doctor. Some drugs require prior authorization from the Plan. It is the prescribing doctor's responsibility to obtain the Plan's authorization.

Covered medications and accessories include:

- Drugs for which a prescription is required by federal law
- Fertility drugs
- Insulin, with a copay charge applied to one month's supply; diabetic supplies are covered under Medical and Surgical Benefits
- Disposable needles and syringes needed to inject covered prescribed medication; Covered under Medical and Surgical Benefits (see page xx).
- Smoking cessation drugs and medication, that require a prescription are covered as a once in a lifetime benefit up to 90 consecutive days
- Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape, Benedict's solution or equivalent, glucose monitors and acetone test tablets are covered under Medical and Surgical Benefits
- Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs, are covered under Medical and Surgical Benefits

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Fluoride for members over age 10
- Contraceptive drugs and devices; Depo Provera; Norplant
- Drugs for cosmetic purposes

Other Benefits

Dental care

Accidental injury benefit

- Drugs to enhance athletic performance
- Drugs to aid in weight loss

Usual, customary, and reasonable expenses of a licensed dentist incurred for dental work necessary for the immediate repair of a non-occupational injury to natural teeth or jaw fracture. Before the injury, the teeth must have been whole and functionally sound, or restored to a sound, functional capacity. Treatment plans must be pre-authorized by the Plan. You pay 20% for services identified by an American Dental Association procedure code; you pay nothing for other covered services.

What is not covered

- Realignment of teeth due to jaw injury
- Repair of broken or damaged teeth caused by biting or chewing
- Dental services or supplies relating to the diagnosis or treatment of temporomandibular joint dysfunction
- Orthodontic services; splints, night guards, and others used to increase vertical dimensions, and restore the occlusion (bite); gnathologic recordings
- Study models of teeth and surrounding tissue
- Hospital or outpatient services
- Cosmetic services including complications resulting from cosmetic surgery
- Surgical placement or removal of implants or attachments to implants
- Routine dental services, including but not limited to cleanings, X-rays, fillings, and extractions
- All dental services not shown as covered

Vision care

What is covered

In addition to the medical and surgical benefits provided for the diagnosis and treatment of diseases of the eye, eye refractions (to provide a written lens prescription for eyeglasses) may be obtained from Plan providers once every 24 months for members through age 17. You pay a \$5 copay.

What is not covered

- Refractions for members age 18 and older
- Eye exercises
- Corrective eyeglasses and frames or contact lenses (including the fitting of the lenses)
- Surgical procedures to correct refractive errors

Smoking cessation program

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium; any charges for these services do not count toward any FEHB deductibles, out-of-pocket maximum copay charges, etc. These benefits are not subject to the FEHB disputed claims procedures.

Medicare prepaid plan enrollment — This plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 4, annuitants and former spouses with FEHB coverage and Medicare Part B, may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those **without** Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the Plan, ask whether the Plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 541/686-2544 or 800/421-0544 ext. 2544 for information on the Medicare prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 541/686-2544 or 800/421-0544 ext. 2544.

Benefits on this page are not part of the FEHB contract

How to Obtain Benefits

Questions

Members who complete an approved smoking cessation program will be reimbursed at 80% of charges up to \$100 once per lifetime.

Disputed claims review

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Customer Service Representative at 541/485-2145 (or outside local call area 1-800/421-0544), or you may write to the Plan at P.O. Box 10106, Eugene, OR 97440.

Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

How to Obtain Benefits *continued*

OPM review *cont.*

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 4, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement — If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

How SelectCare® Changes January 1998

Do not rely on this page; it is not an official statement of benefits.

Benefit changes

Program-wide Changes:

This year, the Office of Personnel Management (OPM) instituted minimum benefit levels in all plans for normal deliveries (48 hours of inpatient care), caesarian sections (96 hours of inpatient care) and mastectomies (48 hours of inpatient care). See page 11 for this Plan's benefits. The routine mammography screening schedule is on page 11.

OPM also requires each prepaid plan to list the specific artificial insemination procedures that it covers. See page 12 for this Plan's benefits.

Changes to this Plan:

- Surgery in a doctor's office will be covered subject to a \$5 copayment per visit instead of no member copayment.
- Prosthetic appliances will be covered subject to a member copayment of 20% of charges instead of no member copayment.
- Outpatient short-term therapy rehabilitative office visits will be covered subject to a \$5 copayment per visit instead of \$15 per visit.
- Copayments for durable medical equipment and supplies, and prosthetic appliances can now be applied to the out-of-pocket limit.
- Transportation and living expenses of the donor and member are covered up to \$250 per day up to a maximum of \$20,000 per transplant. Previously, this was not a covered benefit.
- Under the inpatient short-term rehabilitative therapy benefit, rehabilitation services for cerebral vascular accidents, burns, fractures, or related conditions are no longer limited to two months.
- Diagnosis and treatment of infertility, including artificial insemination, will be covered subject to a \$5 copayment per visit instead of a copayment of 50% of charges.
- Fertility drugs will be covered under the Prescription Drug Benefit subject to a \$5 copayment for generic drugs and a \$10 copayment for brand name drugs instead of a copayment of 50% of charges.
- Orthotic devices including fitting and follow-up exam as required as a result of surgery, congenital defect or diabetes will now be covered subject to a member copayment of 20% of charges. The member is limited to two pair of devices every two years and a maximum Plan payment of \$200 in two years.
- Emergency ambulance transportation copayment of \$25 will be waived if the member is admitted directly to the hospital. Previously, the copayment was not waived.
- The combined maximum limitation for the inpatient and outpatient treatment of alcoholism, drug addiction or drug abuse has been eliminated.

Notes

Summary of Benefits for SelectCare® – 1998

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS**

Benefits	Plan pays/provides	Page
Inpatient care	Hospital Comprehensive range of medical and surgical services with no dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay nothing 13	13
	Extended care All necessary services, for up to 60 days per illness or injury. You pay nothing 13	13
	Mental conditions Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. You pay a \$50 copay per day 16	16
	Substance abuse Services in an alcohol detoxification or rehabilitation center will be covered for up to \$4,500 for adults and \$4,000 for children in any 24-consecutive-month period or for residential care, up to \$3,500 for adults and \$3,000 for children in any 24-consecutive-month period. You pay nothing 16	16
Outpatient care	Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. You pay \$5 per office visit; \$5 per house call by a doctor; copays are waived for maternity care 11, 12	11, 12
	Home health care All necessary visits by nurses and health aides. You pay nothing 11, 12	11, 12
	Mental conditions Up to 20 outpatient visits per year. You pay \$15 copay per visit 16	16
	Substance abuse Up to 20 visits or Plan payment of \$750 adults/\$1,000 children under age 18, whichever is greater, per calendar year; you pay \$15 copay per visit. 16	16
Emergency care	Reasonable charges for services and supplies required because of a medical emergency. You pay the lesser of 50% of the emergency room charges or \$50 per hospital emergency room visit to the hospital for each emergency room visit, a \$25 copay for emergency ambulance transportation and any charges for services that are not covered by this Plan (emergency room and ambulance copays are waived if admitted directly to the hospital from the emergency room); or \$5 copay per urgent care center or physician office visit.. 14, 15	14, 15
Prescription drugs	Drugs prescribed by a Plan doctor are provided. The Plan will reimburse 80% of the prescription cost after an annual \$50 deductible has been met for drugs purchased at any nonparticipating licensed pharmacy in the United States. For drugs from a participating pharmacy or up to a 90-day supply of maintenance drugs ordered from mail order program, you pay a \$10 copay per prescription or refill for name brand drugs and a \$5 copay per prescription or refill for generic drugs. 17	17
Dental care	Accidental injury benefit only; you pay 20% 18	18
Vision care	One refraction per 24-month period for children through age 17. You pay a \$5 copay 18	18
Out-of-pocket limit	Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of \$500 per Self Only or \$1,500 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include charges for prescription drugs or non-covered benefits 8	8