
Section 2. How we change for 2006

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

Program-wide changes

- On page 10, under **Covered providers**, Arizona and West Virginia are designated as medically underserved areas in 2006. Texas is no longer designated as a medically underserved area in 2006.

Changes to this Plan

Changes to our Standard Option only

- Your share of the non-Postal premium will increase by 14.5% for Self Only or 14.8% for Self and Family.
- We now provide limited benefits for services provided by licensed chiropractors. (See page 43.)
- We now provide limited benefits for services provided by licensed acupuncturists. (See page 43.)

Changes to our Basic Option only

- Your share of the non-Postal premium will not change for Self Only or for Self and Family.
- We now provide benefits in full for diagnostic tests billed by the outpatient department of a hospital or ambulatory surgical center. Previously, these services were subject to a \$40 copayment. (See pages 62 and 63.)
- Your responsibility for covered inpatient maternity care billed by a Preferred facility (including Preferred birthing facilities) is limited to \$100 per admission. Previously, members paid a copayment of \$100 per day, up to \$500 for the admission. (See page 32.)
- Your copayment for formulary brand-name drugs is increased from \$25 to \$30 for up to a 34-day supply. (See page 83.)

Changes to both our Standard and Basic Options

- We now provide Preventive care benefits for colonoscopies when performed for cancer screening. (See page 30.)
- We now provide Preventive care benefits for ultrasound screenings for aortic abdominal aneurysms. (See page 30.)
- We now provide Preventive care benefits for children who receive meningococcal vaccines. (See page 31.)
- We now provide benefits for outpatient cognitive rehabilitation therapy when performed by a licensed therapist or physician. (See page 37.)
- We now provide benefits for penile prosthesis to treat erectile dysfunction resulting from prostatectomy to treat prostate cancer. (See pages 40, 48, and 98.)
- We now provide benefits for up to 4 visits per year for outpatient nutritional counseling when billed by a covered provider. This visit limitation does not apply to outpatient nutritional counseling provided for the treatment of anorexia or bulimia. (See page 44.)
- We expanded our coverage for organ/tissue transplants to include coverage for additional diagnoses. In addition, we clarified the benefits provided for transplant support services. (See the section beginning on page 50.)
- We now provide benefits for pulmonary rehabilitation performed and billed by the outpatient department of a hospital or freestanding ambulatory facility. (See page 62.)
- We changed the way we calculate our allowance for covered services you receive from Non-participating professionals. For Non-participating professional care, our allowance is equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount) or 2) the 2006 Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained. Previously, we used 80% of the UCR amount in our benefit calculation. (See page 113.)
- We changed our allowance for certain covered services you receive at Non-member facilities. For most types of inpatient stays at Non-member facilities, our allowance is based on a per diem amount for your type of admission developed from the average amount paid for our members nationally to contracting and non-contracting facilities. For inpatient stays resulting from medical emergencies or accidental injuries, or for routine deliveries, our allowance is the billed amount. For outpatient, non-emergency surgical services provided by Non-member facilities, our allowance is the average amount for outpatient surgical services that we pay nationally to contracting and non-contracting facilities. For other outpatient services provided by Non-member facilities, and for outpatient surgical services resulting from a medical emergency or accidental injury, our allowance is the billed amount (minus any amounts for noncovered services). (See pages 59 and 113.)
- Benefits for dental accidental injury care are no longer limited to care completed within 12 months of the accident. (See page 89.)