



Oxford Health Plans (PA)

1998

A Health Maintenance Organization with a Point of Service product

Serving: Southeastern Pennsylvania

You must live in the service area to enroll in this Plan.



Enrollment code:

3W1 Self Only

3W2 Self and Family

Service Area: Services from Plan providers are available only in the following area:
The *Pennsylvania* counties of Berks, Bucks, Chester, Delaware, Montgomery and Philadelphia.

Special notice: This Plan is being offered for the first time under the Federal Employees Health Benefits Program during the 1997 Open Season. Previously, Pennsylvania was a service area of its parent corporation, Oxford Health Plans, Inc. If you are currently enrolled in Code 3W (Pennsylvania service area) and you do not make a change during the 1997 Open Season, you will be automatically transferred to this new Plan.

Visit the Plan's web site at www.oxhp.com

Authorized for distribution by the:



**United States
Office of
Personnel
Management**



RI 73-764

Oxford Health Plans (PA)

Oxford Health Plans (PA), Inc., 800 Connecticut Avenue, Norwalk, Connecticut 06854, has entered into a contract (CS 2832) 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 Oxford Health Plans, or Oxford, 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 provisions 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.

Table of Contents

	Page
Inspector General Advisory on Fraud	3
General Information	3-6
Confidentiality; If you are a new member; If you are hospitalized when you change plans; Your responsibility; Things to keep in mind; Coverage after enrollment ends (Former spouse coverage; Temporary continuation of coverage; and Conversion to individual coverage)	
Facts about this Plan	7-9
Who provides care to Plan members?; Role of a primary care doctor; Choosing your doctor; Referrals for specialty care; Authorizations; For new members; Hospital care; Out-of-pocket maximum; Deductible carryover; Submit claims promptly; Other considerations; The Plan's service area	
General Limitations	10-11
Important notice; Circumstances beyond Plan control; Other sources of benefits	
General Exclusions	11
Benefits	12-18
Medical and Surgical Benefits; Hospital/Extended Care Benefits; Emergency Benefits; Mental Conditions/Substance Abuse Benefits; Prescription Drug Benefits	
Other Benefits	19-20
Dental care	
Point of Service Benefits	21-22
Non-FEHB Benefits	23-24
How to Obtain Benefits	25-26
How Oxford Health Plans (PA) Changes January 1998	27
Summary of Benefits	28

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 1-800/444-6222 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, N.W., Room 6400
Washington, D.C. 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 SF2809 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 15, or when you self-refer for point of service, or POS, benefits as described on pages 21 and 22.** 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

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 this 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 of 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 or POS 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.

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.

General Information *continued*

You may also remain enrolled in this 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 24 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 also may 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. 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 31-day free 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% 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% administrative charge. TCC for 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.

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 health maintenance organization (HMO) that offers a point of service, or POS, product. Whenever you need services, you may choose to obtain them from your personal doctor within the Plan's provider network or go outside the network for treatment. Within the Plan's network you are required to select a personal doctor who will provide or arrange for your care and you will pay minimal amounts for comprehensive benefits. When you choose a non-Plan doctor or other non-Plan provider under the POS option, you will pay a substantial portion of the charges and the benefits available may be less comprehensive. See pages 21 and 22 for more information.

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 in 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?

Oxford is a private practice health care plan providing health benefits through a network of participating doctors and hospitals. All participating doctors practice in their own offices in the community. Covered benefits are available only from those doctors and from participating hospitals, participating laboratories, participating ancillary providers (*e.g.* home health agencies, MRI facilities, etc.) and participating pharmacies. Oxford arranges with doctors to provide medical care for both the prevention of disease and the treatment of serious illness.

All doctors participating in Oxford's program are Board certified or recent graduates of an accredited residency program.

Role of a primary care doctor

The first and most important decision each family 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 from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when there has been a referral by the member's primary care doctor (or alternatively, from the Plan's Medical Management Department for services related to mental health and substance abuse) or when you use POS benefits, with the following exception: a woman may see her Plan obstetrician/gynecologist or nurse midwife directly, with no need to be referred by her primary care doctor.

Choosing your doctor

The Plan's Roster of Participating Physicians lists primary care doctors (generally family practitioners, pediatricians and internists) and obstetrician/gynecologists with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Rosters are updated on a regular basis and are available at the time of enrollment or upon request by calling the Member Services Department at 1-800/444-6222; you can also find out if your doctor participates with this Plan by calling this number or by using the provider search feature of Oxford's web site. If you are interested in receiving care from a specific provider who is listed in the roster, 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 or POS 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 complete a primary care doctor selection form and send it directly to the Plan, indicating the name of the primary care doctor(s) you select for you and each member of your family. Members may change their doctor selection by calling the Member Services Department at 1-800/444-6222.

If you are receiving services from a doctor who leaves the Plan, the Plan will pay for covered services until the Plan can arrange with you for you to be seen by another participating doctor.

Referrals for specialty care

Except in a medical emergency, or when a primary care doctor has designated another doctor to see his or her patients, or when you choose to use the Plan's POS benefits, 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 primary care doctor's discretion; if non-Plan specialists or consultants are required, the primary care doctor will arrange for appropriate referrals. Members who wish to self-refer to a doctor of their choice can use the POS Freedom Plan benefits (see pages 21 and 22).

When you receive a referral from your primary care doctor, you should contact the primary care doctor after the consultation. All follow-up care must be provided or authorized by the primary care doctor. On referrals, 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 the primary care doctor. Do not go to the specialist unless your primary care doctor has arranged for, and, if necessary, the Plan has issued an authorization for, the referral in advance.

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.

Your primary care doctor or authorized specialist must obtain the Plan's determination of medical necessity before all non-emergency hospitalizations, outpatient procedures performed at a hospital facility, and for all surgical or major diagnostic procedures regardless of where they are performed. The Plan reserves the right to require second surgical opinions (and, if necessary, third opinions) from Plan providers, at no cost to the member. See page 21 for precertification requirements under the POS Freedom Plan.

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 Plan primary care doctor for the care to be covered by the Plan. If the doctor who originally referred you to this specialist 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 for your next appointment.

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

Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments which are required for a few benefits. If the total of your copayments exceeds \$1,058 for a Self Only enrollment or \$2,769 for a Self and Family enrollment, you may apply to the Plan within 45 days of the end of the calendar year for reimbursement of the difference. This copayment maximum does not include charges for prescription drugs and dental care. See page 22 for the out-of-pocket maximums you pay when you use POS benefits.

You should maintain accurate records of any out-of-pocket costs, as it is your responsibility to determine when the payment maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs when you use standard HMO benefits. 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.

Facts about this Plan *continued*

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. Claims for POS Freedom Plan benefits may be submitted by the member or provider. You may submit claims to Oxford Health Plans, P.O. Box 7082, Bridgeport, CT 06601-7082.

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 which may be recommended by Plan providers.

The Plan's service area

The service area for this Plan, where Plan providers are located, is described on the front cover of this brochure. You must live in the service area to enroll in this Plan. Benefits for care outside the service area are limited to emergency benefits, as described on page 15, and to services covered under Point of Service Benefits, as described on pages 21 and 22.

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 your employing office or retirement system for information if you are anticipating a move.

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 plan, special limitations on your CHAMPUS coverage apply; your primary care provider must authorize all care unless you use a non-Plan provider (or a Plan specialist without a referral) for POS benefits as described on pages 21 and 22. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

Medicaid

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

General Limitations *continued*

Workers' compensation

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).

DVA facilities, DoD facilities, and Indian Health Service

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.

Other Government agencies

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

Liability insurance and third party actions

If a covered person is injured or becomes ill through the act of a third party, the Plan will provide coverage for the treatment of such injury or sickness. Upon providing treatment for such injury or sickness, the Plan shall be permitted to recover the reasonable value of such care for injury or sickness, when payment is made directly to the covered person in third party settlements or satisfied judgments. This reimbursement provision is enforceable only to the extent it is permitted by state law or regulations.

General Exclusions

All benefits are subject to the definitions, 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:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see Emergency Benefits) or for eligible self-referred services obtained under Point of Service Benefits (see pages 21 and 22 for the POS Freedom Plan);
- 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 and supplies related to sex transformations; and
- 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.

Medical and Surgical Benefits

What is covered 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 \$10 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 \$10 copay for a doctor's house call and a \$10 copay for home visits by nurses, physical or occupational therapists, and health aides.

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 (office visit copay is waived)
- Mammograms are covered as recommended by your doctor. At a minimum, mammograms are covered as follows: for women age 35 through 39, one mammogram during these five years; for women age 40 and above, one mammogram every year. (the copay is waived)
- Routine immunizations and boosters (office visit copay is waived when services are rendered as part of a preventive care visit)
- Consultations by specialists
- Diagnostic procedures, including laboratory tests and X-rays
- 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, except for the initial diagnosis visit). The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean 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 (including tubal ligations and vasectomies) and family planning services (except IUD's)
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including test and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers, intraocular lenses following cataract removal and artificial joints
- Nonexperimental transplants, including cornea, heart, heart-lung, lung (single or double), kidney, liver and pancreas transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Additionally, autologous bone marrow transplants (autologous stem and peripheral stem cell support) and high dose chemotherapy for the following conditions: breast cancer, multiple myeloma and epithelial ovarian cancer. Transplants are covered when approved by the Plan's Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- 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.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- External prosthetic devices, such as artificial limbs
- Chiropractic services (but not products)
- Home health services of nurses, physical or occupational therapists, 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
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you

Medical and Surgical Benefits *continued*

Limited benefits

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 intra-oral 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 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 basis for up to 60 consecutive days per condition per lifetime and/or on an outpatient basis for up to 60 visits per condition per lifetime if significant improvement can be expected; **you pay** nothing for inpatient sessions and a \$10 copay per outpatient session. Speech therapy is limited to treatment of certain speech 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. Physical therapy must begin within 6 months of the later of the injury/illness, hospital discharge or outpatient surgery and must be completed within 365 days of the event.

Diagnosis and treatment of infertility is covered; **you pay** a \$10 office visit copay. All types of artificial insemination, including intrauterine insemination (IUI), intracervical insemination (ICI) and intravaginal insemination (IVI), are covered; **you pay** a \$10 office visit copay; the cost of donor sperm is not covered. Fertility drugs are not covered. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization and embryo transfer are not covered.

Cardiac rehabilitation is limited to Phase II rehabilitation for angina and following a heart transplant, bypass surgery, angioplasty, or a myocardial infarction, and is provided for up to 36 outpatient sessions; **you pay** nothing.

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
- Reversal of voluntary, surgically-induced sterility
- Plastic surgery primarily for cosmetic purposes
- Hearing aids
- Long-term rehabilitative therapy
- Orthopedic devices, such as braces; foot orthotics
- Homemaker services
- Durable medical equipment, such as wheelchairs and hospital beds
- Replacement or repair of external prosthetic devices (except in children when the previous device has been outgrown)
- Whole blood, plasma and blood derivatives, if participation in a volunteer blood replacement program is available to the member. Also, synthetic blood, apheresis or plasmapheresis, and the cost of securing the services of professional donors
- Acupuncture therapy
- Aphakic contact lenses following cataract surgery

Hospital/Extended Care Benefits

What is covered

Hospital care

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
- Specialized care units, such as intensive care or cardiac care units
- Autologous blood banking services, in connection with a scheduled covered procedure

Extended care

The Plan provides a comprehensive range of benefits for up to 30 days per member per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is in lieu of hospitalization. **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

Support and palliative care for a terminally ill member is covered in the home or a 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 or less. Benefits are limited to 180 days; **you pay nothing**.

Ambulance service

Benefits are provided for ambulance transportation ordered by or authorized by a Plan doctor.

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 17 for nonmedical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care, rest cures, domiciliary or convalescent care
- Whole blood, plasma and blood derivatives, if participation in a volunteer blood replacement program is available to the member. Also, synthetic blood, apheresis or plasmapheresis and the cost of securing the services of professional donors

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS TO RECEIVE STANDARD HMO BENEFITS

Emergency Benefits

What is a medical emergency?

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 was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

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 you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Your primary care doctor will provide the necessary care, refer you to other Plan providers, or make arrangements with other providers. Benefits are available for care from non-Plan providers in a medical emergency **only** if a delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition (except as shown on pages 21 and 22).

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers except as covered under POS benefits.

Plan pays...

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

You pay...

\$35 per hospital emergency room visit or \$10 per precertified visit to a designated urgent care center for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the copay is 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 better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers except as covered under POS benefits.

Plan pays...

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

You pay...

\$35 per hospital emergency room visit or \$10 per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

What is covered

- 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

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 of a baby outside the service area except as covered under POS benefits.

Emergency Benefits *continued*

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 and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on pages 25 and 26.

Mental Conditions/Substance Abuse Benefits

For services, contact the Plan at 1-800/201-6991.

Mental conditions

What is covered

To the extent shown below, this 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

Up to 30 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; **you pay** 50% of covered charges for each covered visit—all charges thereafter.

Inpatient care

Up to 35 days of hospitalization each calendar year; **you pay** nothing for the first 35 days—all charges thereafter.

What is not covered

- 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 that is 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

Up to 60 outpatient visits (which may include visits for the member's family) to Plan providers for treatment each calendar year; **you pay** nothing for the first 60 visits—all charges thereafter. Up to 30 of the outpatient visits may be exchanged for additional inpatient days on a 2 for 1 basis.

Inpatient care

Up to 35 days each calendar year in a designated alcohol or drug rehabilitation center, plus up to 15 additional days (if outpatient visits are exchanged as stated above); **you pay** nothing for all covered days—all charges thereafter.

What is not covered

- Treatment that is not authorized by a Plan doctor.

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply or 120-unit supply, whichever is less, or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin). **You pay** a \$5 (generic)/\$10 (name brand) copay per prescription unit or refill. Access to some drugs is subject to prior Medical Director approval. Also, a mail order service is available for certain maintenance medications for up to a 90 day supply; **you pay** a \$5 copay.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Insulin
- Disposable needles and syringes needed for injecting covered prescribed medication, including insulin

Intravenous fluids and medications for home use (provided under Home health services at no charge), implantable drugs except Norplant, 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
- Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies
- Vitamins and nutritional substances which can be purchased without a prescription
- Medical supplies, such as dressings and antiseptics
- Oral and injectable contraceptive drugs and contraceptive devices; Norplant; Depo Provera (for other than a diagnosis of endometriosis)
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Drugs for weight control
- Drugs to aid in smoking cessation
- Fertility drugs
- Diabetic supplies

Other Benefits

Dental care

What is covered

The following dental services are covered when provided by a pre-selected Plan primary care dentist; **you pay** nothing (office visit copayment is waived). Each family member's primary care dentist may be changed once a year by writing to the Plan and the change will become effective on the first day of the month following receipt of the request.

- Routine exam every 6 months
- Prophylaxis (cleaning), including scaling and polishing, every 6 months
- Topical application of fluoride for children, as needed
- Preventive dental instructions
- X-rays, including bitewings (as needed) and full mouth or panorex (every 3 years)
- Oral cancer exam
- Study models

For all other dental care with Plan primary care dentists, **you pay** a \$3 office visit copayment plus the corresponding copayment listed below:

	You pay
	Sealants (per tooth) \$20
	Scaling (follow-up to initial prophylaxis when needed) \$35
Fillings	
	Amalgam (silver fillings):
	one surface \$20
	two surfaces \$40
	three surfaces \$55
	four surfaces or more \$65
	Composite resin (white fillings):
	one surface \$35
	two surfaces \$45
	three surfaces \$70
	four surfaces or more (involving incisal angle) \$80
Extractions	Simple, per tooth \$30
Root canal therapy	Anterior \$225
	Bicuspid \$260
	Molar \$370
Pulpotomy	Removal of nerve tissue on primary teeth (not root canal) \$50
Full denture	Upper or lower \$500
Partial denture	Upper or lower (regardless of the number of teeth needed to be replaced or the number of clasps) \$475
Crown and bridge (per unit)	Porcelain fused to metal crown \$425
	Full cast crown \$400
	Inlays (metallic or porcelain):
	two surfaces \$250
	three surfaces \$290
	Onlay in addition to inlay \$100
	Post and core in addition to crown \$130
	Recement crown / bridge \$30
Night guard	Hard or soft \$125
Emergency dental visits	\$30
Broken appointments	(Less than 24 hours notice) \$20

Other Benefits *continued*

What is covered (continued)

Specialist services do not require a referral from the primary care dentist. For all care from Plan specialty care dentists, **you pay** a \$3 office visit copayment plus the corresponding copayment listed below:

Oral surgery (specialist)	You pay
Consultation	\$50
Full mouth or Panorex x-rays	\$40
Single x-rays	\$5
Simple extraction, single tooth	\$55
Surgical extraction of erupted tooth	\$80
Extraction, soft tissue impaction	\$100
Extraction, partial bony impaction	\$165
Extraction, full bony	\$180
Apicoectomy (per tooth)	\$245
Retrograde filling	\$45
General anesthesia (per 1/2 hour)	\$80
Nitrous oxide sedation (per 1/2 hour)	\$20
Local anesthesia	nothing

Patient will be liable for hospital, physician and other medical costs in the event oral surgery is performed in a hospital or in a surgical setting other than the dentist's office.

Endodontics (specialist)	\$50
Consultation	\$50
Full mouth or Panorex x-rays	\$40
Single x-rays	\$5
Root canal therapy:	
Anterior	\$300
Bicuspid	\$350
Molar	\$450
Apicoectomy (per tooth)	\$245
Retrograde filling	\$45

Orthodontics (specialist)	\$25
Initial consultation (applied toward case fee)	\$25
Diagnostic records (includes x-rays)	\$120
Comprehensive orthodontic treatment (child/adolescent)	\$2700
Comprehensive orthodontic treatment (adult)	\$3100
Retainer (each)	\$165

Replacement of lost or broken appliances are the responsibility of the Member.

Pediatric dentistry (specialist)	\$30
Exam/prophylaxis	\$30
Panorex or full mouth x-rays (including bitewings)	\$40
Single x-rays	\$5
Sealants, per tooth	\$25
Amalgams (silver fillings):	
One surface	\$35
Two surfaces	\$50
Three surfaces	\$70
Extractions:	
Simple, single tooth	\$50
Surgical, erupted tooth	\$75

Periodontics (specialist)	\$50
Consultation	\$50
Full mouth or Panorex x-rays	\$40
Single x-rays	\$5
Periodontal scaling and root planing, per quadrant	\$100
Gingivectomy or gingivoplasty, per quadrant	\$175
Osseous surgery, per quadrant	\$560
Maintenance scaling (following active therapy)	\$75
Full mouth debridement	\$50

Fees include post-surgical services.

Emergency visits (specialist)	\$35
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Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury and the services must be obtained within 12 months of the injury. **You pay** nothing.

What is not covered

- Other dental services not shown as covered

Point of Service (POS) Benefits

Facts about this Plan's POS option (the Freedom Plan)

Members may use non-Plan providers of their choice.

What is covered

At your option, you may choose to obtain non-emergency benefits covered by this Plan from non-Plan doctors, hospitals or other eligible healthcare providers, without a referral, whenever you need care, except for benefits listed below under "What is not covered." Covered POS benefits, including hospital care, are paid on a fee-for-service basis when services are received from non-Plan providers, or from Plan providers without a valid referral, and are subject to the deductibles and coinsurance stated below. Benefits for services covered under both the Plan's standard HMO benefits and POS benefits, when combined, can not exceed any day or visit limitations imposed under the standard HMO benefits.

Benefit payments will be subject to a \$250 deductible for Self Only; \$625 for Self and Family enrollment. The Plan pays 80% of the reasonable and customary (R & C) charges. **You pay** 20% of the R & C charges and all charges in excess of the R & C charges.

Chiropractic visits, including one set of chiropractic x-rays, are covered subject to the member's deductible and to a maximum payable benefit of \$500 per calendar year. **You pay** 50% of the R & C charges and all charges thereafter.

Mental health and substance abuse benefits are covered subject to the member's deductible and then **you pay** 50% of the R & C charges and all charges thereafter.

Maximum benefit

All POS benefits under the Freedom Plan are limited to a total maximum payment by the Plan of \$1,000,000 per member, per lifetime.

Precertification requirement

The purpose of precertification is to ensure that benefits are provided only for medically necessary care and at the most suitable site for care. This precertification process must be completed in order to receive benefits for covered hospital expenses after any applicable deductibles and coinsurance. A telephone call must be made to Oxford by you or your doctor 14 days prior to admission to a hospital. In an emergency, Oxford must be notified within 48 hours, or at the earliest reasonable time. The toll-free number is 1-800/444-6222, or 1-800/899-9039 after 5:00 p.m. All hospital admissions must be precertified as to medical necessity. If precertification is not obtained, payable benefits are reduced by 20%.

The following information must be provided to Oxford:

- Your Oxford I.D. number (from membership card)
- Your name, birth date and phone number
- Name and telephone number of doctor
- Hospital name and location
- Reasons for hospitalization
- Proposed treatment or surgery
- Number of planned days of confinement

In addition to inpatient hospital admissions, all outpatient services performed at a hospital, most surgeries, maternity care, all mental health and substance abuse care, hospice care, cardiac rehabilitation, dialysis and home health care must be precertified or payable benefits will be reduced by 20%. Second (and possibly, third) surgical opinions from Plan providers may be required, at no cost to the member.

Deductible

The calendar year deductible only applies to POS claims and is the amount of covered expenses an individual must incur before the Plan pays benefits that are subject to the deductible. The deductible (subject to reasonable and customary charges) is \$250 per Self Only enrollment or \$625 per Self and Family enrollment (with a maximum of \$250 per family member) and is not reimbursable by the Plan. If you decide to use non-Plan providers, this deductible applies to all benefits, except prescription drugs purchased at a Plan pharmacy. Copays under Oxford's standard HMO benefits cannot be used to meet the calendar year deductible.

Point-of-Service Benefits *continued*

Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductibles. You are required to pay 20% of the reasonable and customary (R & C) charges on benefits for covered services obtained from non-Plan providers and the Plan will pay 80% of the R & C charges. Charges for covered services that exceed the R & C charges and/or the lifetime maximum benefit are the responsibility of the member.

Out-of-pocket maximum

When the coinsurance that you pay in any calendar year for POS benefits (other than chiropractic, mental health and substance abuse) reaches \$2,000 per Self Only enrollment or \$5,000 per Self and Family enrollment, the Plan will thereafter pay 100% of the R & C charges. The deductible paid is not included in the out-of-pocket maximum.

What is not covered

- Dental care
- Treatment of infertility, and artificial insemination
- Inpatient private duty nursing
- Services excluded under the standard HMO benefits

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 of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles, POS maximum benefits or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Vision Care: Once every two years, members may receive the following services from participating providers:

Eye exam	\$5 copay
Lenses (glass or plastic) in single vision, bifocal, trifocal or aphakic	No charge
Fashion frames	\$10 copay
Designer or metal frames	\$25 copay
Premier frames	\$35 copay
Fashion or gradient tinting of plastic lenses	No charge
Standard soft daily wear contact lenses (in lieu of eyeglasses).....	\$25 copay
All other contact lenses (in lieu of eyeglasses).....	\$60 allowance

Other frames and lens options are available at various copayments or subject to a specified allowance. Members also may elect to use non-participating providers and receive a specified indemnity reimbursement instead.

Detailed information about this benefit, and a provider listing, may be obtained by calling 1-800/999-5431.

Additional Dental Care:

All services not listed as covered on pages 19 and 20 of this brochure will be provided by Plan dentists at a 20% discount off their usual fees.

Additional Mail Order Prescription Drug Benefits:

Certain name brand prenatal vitamins and children's fluoride vitamins @ \$10 copay for a 100 day supply.
Certain name brand oral contraceptives @ \$20-\$30 copay for 3 cycles (or \$80-\$120 for 13 cycles).

Alternative Medicine Program:

- Self-referred access to a credentialed network of acupuncturists, chiropractors, massage therapists, naturopaths, yoga instructors and nutritionists. Members are provided services at guaranteed contracted rates. Payment is made directly to the provider.
- *Living Balance* mail order and internet catalog — Members can purchase a wide variety of nutritional supplements, natural remedies, natural hair and skin care products, educational reference media, relaxation music and more, at discounts ranging up to 25% below suggested retail prices.
- Unlimited access to *Conventional and Alternative Remedies Encyclopedia* via Oxford's web site.

Wellness and One-to-One Management Programs:

At Oxford, we believe that there should be more to a health plan than just paying the bills when you are sick. It should encourage you to maintain a healthy lifestyle. The following programs embody this philosophy.

- **Healthy Bonus Program** — Features discounted fees and special offers on various products and services which promote general wellness and preventive care. Please note that Oxford has no financial or other interest in any of the participating companies.
- **Active Partner Program** — Reminds members when they have not seen their Oxford Primary Care Physician for a physical in the past two years. Reminds female members to see their Oxford Ob/Gyn for pap smears, mammographies and pelvic exams. Reminds parents to have their infants immunized. Reminds diabetics to have annual retinal exams. Reminds members over 65 to get flu shots.
- **Healthy Mother, Healthy Baby Program** — A maternity program designed to improve the health and well being of pregnant women and their newborns through a variety of educational materials and toll-free nurse counseling support. Extra case management services are available for members who meet specific high risk criteria.
- **Better Breathing Program** — An asthma case management program designed to educate members and help improve their quality of life while partnering with physicians to ensure they are treating according to the latest treatment guidelines. Additional case management services to members with severe asthma are provided.

Benefits on this page are not part of the FEHB Contract

Non-FEHB Benefits Available to Plan Members *continued*

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 of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles, POS maximum benefits or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Wellness and One-to-One Management Programs: *continued*

- **Self-Help Series** — Members can obtain comprehensive information about managing chronic conditions in order to improve their quality of life. The series currently includes brochures on breast or skin cancer, adult or childhood asthma, adult or juvenile diabetes, chronic headaches, sinusitis, hypertension and heart disease.
- **Healthy Mind, Healthy Body Magazine** — A quarterly magazine filled with general health and fitness information, and Oxford administrative news.

Oxford On-Call:

A 24-hour healthcare assistance service staffed by Registered Nurses trained in emergency care. Nurses help guide members in self-care, help make appointments with physicians or advise the seeking of emergency care.

Medicare Prepaid Plan Enrollment:

This Plan offers Medicare recipients the opportunity to alternatively enroll in the Oxford Medicare Advantage Plan through Medicare without payment of an FEHB premium if they have Medicare Parts A and B. 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 re-enroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those **without** Medicare Part A may join this Medicare prepaid plan, but will have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask what you will have to pay for hospital benefits. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-800/303-6720 for information on the Medicare prepaid plan (the Oxford Medicare Advantage Plan) and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in the Medicare prepaid plan sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-800/303-6720 for information on the benefits available under the Oxford Medicare Advantage Plan.

Benefits on this page are not part of the FEHB Contract

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Member Services Department at 1-800/444-6222 or TDD# 203/851-2300 (for the hearing impaired), or you may write to the Plan at P.O. Box 7082, Bridgeport, CT 06601-7082.

Disputed claims review

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 the 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, 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.

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

How to Obtain Benefits *continued*

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 Oxford Health Plans (PA) Changes January 1998

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

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), caesarean sections (96 hours of inpatient care) and mastectomies (48 hours of inpatient care). See page 12 for this Plan's benefits.

The mammogram screening schedule is shown on page 12.

- OPM also requires each prepaid plan to list the specific artificial insemination procedures that it covers. See page 13 for this Plan's benefits.

Changes to this Plan

- The Plan's service area has expanded to include Berks County in Pennsylvania. See the front cover for a complete description.
- Outpatient cardiac rehabilitation is now covered with no copayment. See page 13 for details.
- Female members may now self-refer to a participating nurse midwife in lieu of a participating obstetrician/gynecologist, when using standard HMO benefits.
- The Plan now has an out-of-pocket maximum for copayments when you use standard HMO benefits. See page 8 for details.
- Chiropractic services are now covered under the standard HMO benefits. See page 12 for details.
- Autologous blood banking services are now covered under both the standard HMO benefits (at no cost to the member) and Point of Service benefits when done in connection with a scheduled procedure.
- Hospice care is now covered for up to 180 days. Previously, coverage was provided for up to 210 days. See page 14 for details.
- Bereavement counseling for a member's family upon their death is no longer covered.
- Up to 30 of the maximum 60 outpatient visits per calendar year for substance abuse treatment can now be exchanged on a 2 for 1 basis for additional inpatient days of substance abuse treatment. See page 17 for details.
- The \$50 per member deductible for prescription drugs has been eliminated. See page 18 for details.
- Diabetic supplies are no longer covered. However, insulin is still covered through the Plan's prescription drug benefits. See page 18 for details.
- Preventive care services (e.g., physical examinations, routine pediatric care, well-woman exams and immunizations) are now covered under Point of Service benefits.
- Under Point of Service benefits, all mental health and substance abuse care is now covered with a coinsurance of 50% after meeting the POS calendar year deductible. Precertification of these services is required. See page 21 and page 22 for details.
- Under Point of Service benefits, the calendar year deductibles have increased from \$200 to \$250 for a Self Only enrollment, and from \$400 (with a maximum \$200 per family member) to \$625 (with a maximum \$250 per family member) for a Self and Family enrollment.
- Under the Plan's Point of Service benefits, there is now an out-of-pocket maximum benefit. When the coinsurance that you pay in any calendar year for POS benefits (other than chiropractic, mental health and substance abuse) reaches \$2,000 per Self Only enrollment or \$5,000 per Self and Family enrollment, the Plan will thereafter pay 100% of the reasonable and customary charges. See page 22 for details.
- Additional services have been added to the Point of Service precertification requirement. See page 21 for details.
- The Plan has added additional non-FEHB benefits. See pages 23 and 24 for details.

Summary of Benefits for Oxford Health Plans (PA) - 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 AND SERVICES AVAILABLE AS POS BENEFITS, 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 without 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	14
	Extended care All necessary services, up to 30 days per member per calendar year. You pay nothing	14
	Mental conditions Diagnosis and treatment of acute psychiatric conditions for up to 35 days of inpatient care per calendar year. You pay nothing	17
	Substance abuse Up to 35 days (or 50 days if outpatient visits are exchanged) in a substance abuse treatment program per calendar year. You pay nothing	17
Outpatient care	Comprehensive range of services, such as diagnosis and treatment of illness or injury, including specialists' care. You pay a \$10 copay per office visit or house call by a doctor. Preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and x-rays; complete maternity care. You pay nothing	12-13
	Home health care All necessary visits by nurses, physical and occupational therapists, and health aides. You pay a \$10 copay per visit	12
	Mental conditions Up to 30 outpatient visits per calendar year. You pay 50% of charges	17
	Substance abuse Up to 60 outpatient visits (30 of which may be exchanged for additional inpatient days on a 2 for 1 basis) per calendar year. You pay nothing	17
Emergency care	Reasonable charges for services and supplies required because of a medical emergency. You pay a \$35 copay to the hospital for each emergency room visit or a \$10 copay for urgent care center visit and any charges for services that are not covered benefits of this Plan	15-16
Prescription drugs	Drugs prescribed by a doctor and obtained at a Plan pharmacy; you pay a \$5 (generic) or \$10 (name brand) copay per prescription unit or refill. Maintenance medications through a mail order program; you pay a \$5 copayment for up to a 90 day supply	18
Dental care	Accidental injury benefit; you pay nothing. Preventive and diagnostic dental care from participating primary care dentists; you pay nothing. All other dental care from participating primary and specialty dentists; you pay a \$3 office visit copay in addition to various copayments for dental services (see schedule of benefits)	19-20
Vision care	No current benefit	
Point of Service Benefits	Services of non-Plan providers or Plan providers without a valid referral. Not all benefits are covered. You pay deductibles and coinsurance and a maximum benefit applies.	21-22
Out-of-pocket maximum	Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of \$1,058 per Self Only or \$2,769 per Self and Family enrollment per calendar year, you will be reimbursed the difference. This copay maximum does not include charges for prescription drugs and dental care. There is also an out-of-pocket maximum for the charges you pay when you use POS benefits	8 and 22