

# Blue Cross® and Blue Shield® Service Benefit Plan

<http://www.fepblue.org>



2009

## Addendum Summarizing the Basic Consumer Option Program (A High Deductible Health Plan with a Preferred Provider Organization)

To be read in conjunction with the Blue Cross and Blue Shield Service Benefit Plan brochure (RI 71-005)

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

**Who may enroll in this Plan:** Federal employees and annuitants who reside in the following service areas:

- Anthem Blue Cross and Blue Shield of Ohio (State of Ohio)
- Blue Cross and Blue Shield of Minnesota (State of Minnesota)
- Blue Cross and Blue Shield of Tennessee (State of Tennessee)
- Blue Cross and Blue Shield of Kansas City (limited to the counties of Johnson and Wyandotte in the State of Kansas, and the counties of Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Clair, Saline, Vernon, and Worth in the State of Missouri)

**Enrollment codes for this Plan:**

- 114 Basic Consumer Option - Self Only
- 115 Basic Consumer Option - Self and Family



Authorized for distribution by the:



**United States  
Office of Personnel Management**

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## Table of Contents

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Section 1. Basic Consumer Option Overview .....	1
Section 2. How we change for 2009 .....	5
Section 3. Savings – HSAs and HRAs.....	6
Section 4. Preventive Care .....	17
Section 5. Traditional Medical Coverage Subject to the Deductible.....	18
Section 6. Deductible and Catastrophic Protection.....	24
Section 7. Health Education Resources and Account Management Tools.....	26
Section 8. Definitions.....	27

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## Section 1. Basic Consumer Option Overview

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The Blue Cross and Blue Shield Service Benefit Plan Basic Option includes a sub-option called Basic Consumer Option. The Basic Consumer Option provides enrollees and their family members with the opportunity to enroll in a High Deductible Health Plan (HDHP) with a tax-favored Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA). All eligibility, coverage, and administrative rules of the Blue Cross and Blue Shield Service Benefit Plan Basic Option apply unless otherwise noted in this Addendum. As a sub-option within Basic Option, you must use Preferred providers to receive benefits under the Plan, unless otherwise specified in this Addendum or in the Service Benefit Plan brochure. **However, the Basic Consumer Option offers different benefits from Basic Option, so please read this Addendum carefully.**

This Addendum, which describes the Basic Consumer Option benefits, is divided into Sections. Please read *Important things you should keep in mind about these benefits* at the beginning of Sections 3, 4, and 5. Also read Section 6, *General exclusions*, in the Service Benefit Plan brochure; they apply to the benefits in the following Sections. To obtain claim forms, claims filing advice, or more information about the Basic Consumer Option benefits, contact us at the customer service number on the back of your ID card or visit us at our Web site at [www.fepblue.org](http://www.fepblue.org).

### Who may select the Basic Consumer Option

Federal employees and annuitants who reside in the following service areas:

- *Anthem Blue Cross and Blue Shield of Ohio (State of Ohio)*
- *Blue Cross and Blue Shield of Minnesota (State of Minnesota)*
- *Blue Cross and Blue Shield of Tennessee (State of Tennessee)*
- *Blue Cross and Blue Shield of Kansas City (limited to the counties of Johnson and Wyandotte in the State of Kansas, and the counties of Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Clair, Saline, Vernon, and Worth in the State of Missouri)*

Note that if you enroll in the Basic Consumer Option and then move out of the coverage area, you will remain enrolled in the Plan unless you have a qualifying life event that would allow you to make a mid-year change in election. As a general rule, your election to participate in this or any other FEHB plan continues until the next Open Season. For more information about changing your enrollment, please refer to Section 11 of the Service Benefit Plan brochure.

### Premium rates

Basic Option rates apply to the Basic Consumer Option Plan.

### Definitions

Certain capitalized terms used in this Addendum are defined in Section 8 of this Addendum or in Section 10 of the Service Benefit Plan brochure.

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Basic Consumer Option gives you greater control over how you use your health care benefits.

When you enroll in the Basic Consumer Option, we will help you establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) as long as you take the actions specified in Section 3 of this Addendum. We automatically pass through a portion of the total health Plan premium into your HSA or credit an equal amount to your HRA based upon your eligibility. The amount transferred is called the "Premium Pass Through," which is further defined in Section 8 of this Addendum. Your full annual HRA credit will be available on your effective date of enrollment.

With the Basic Consumer Option, preventive care received from Preferred providers is covered in full. Benefits for non-preventive medical care are provided after you meet the Basic Consumer Option calendar year deductible. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing the savings in your HSA to continue to grow. The Basic Consumer Option catastrophic protection maximum is the same as the calendar year deductible; so, once you reach the calendar year deductible, you will not have additional out-of-pocket expenses for covered medical services. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). The services covered under the Basic Consumer Option are the same as those covered under Basic Option.

The Basic Consumer Option includes five key components: preventive care; traditional medical coverage health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

### **Preventive care**

The Basic Consumer Option covers preventive care services from Preferred providers, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), well-child care, and child and adult immunizations. These services are covered at 100% of the Plan allowance if you use a Preferred provider. These covered services are found in Section 5 of the Service Benefit Plan brochure with some additional information in Section 4 of this Addendum. *You do not have to meet the calendar year deductible before receiving benefits for these services.*

### **Traditional medical care**

After you have paid the calendar year deductible, we pay benefits under traditional medical coverage. These covered services are found in Section 5 of the Service Benefit Plan brochure for Basic Option, with some additional information in Section 5 of this Addendum. The Plan typically pays 100% of the Plan allowance for services from Preferred providers.

You must use Preferred providers in order to receive benefits for traditional medical care services. See page 14 of the Service Benefit Plan brochure for the exceptions to this requirement.

Covered services include:

- Medical services and supplies provided by physicians and other health care professionals
- Surgical and anesthesia services provided by physicians and other health care professionals
- Services provided by a hospital or other facility, and ambulance services
- Emergency services/accidents
- Mental health and substance abuse services
- Prescription drug benefits
- Dental benefits

### **Savings**

HSAs or HRAs provide a means to help you pay out-of-pocket expenses (see Section 3 of this Addendum for more details).

- **Health Savings Accounts (HSAs)**

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received any Department of Veterans Affairs (VA) benefits in the previous 3 months outside of disregarded coverage (see *Definitions*) and/or preventive care, are not covered by their own or their spouse's flexible spending account (FSA), and do not have other health insurance coverage other than another HSA-qualified High Deductible Health Plan (HDHP). In 2009, for each month you are eligible for an HSA Premium Pass Through, we will contribute to your HSA \$75 per month for self only enrollment or \$150 per month for self and family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is \$3,000 for an individual and \$5,950 for a family in 2009. See page 9 of this Addendum for information about the maximum contribution you are permitted to make. You can use funds in your HSA to help pay your health plan deductible. You own your HSA; the funds can go with you if you change plans or employment.

**Federal tax tip:** There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By making your voluntary HSA contributions early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contribution and the tax-free interest to accumulate, your HSA continues to grow for future expenses.

**HSA features include:**

- Your HSA is administered by Blue Healthcare Bank
- Your contributions to the HSA are tax-deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest
- You may make tax-free withdrawals for Qualified Medical Expenses (as this term is defined in Section 8 of this Addendum) for you, your spouse, and your dependents (see IRS publication 502 for a complete list of Qualified Medical Expenses)
- Your unused HSA funds and interest accumulate from year to year
- It's portable – The HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need them, funds up to the actual HSA balance are available

**Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA):** If you are enrolled in the Basic Consumer Option with a Health Savings Account (HSA), and start or become covered by an HCFSA (such as the HCFSA that FSAFEDS offers – see Section 12 of the Service Benefit Plan brochure), no contributions can be made to your HSA. Similarly, no contributions can be made to your HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA we will establish an HRA for you.

- **Health Reimbursement Arrangements (HRA)**

If you aren't eligible for an HSA (for example, if you are enrolled in Medicare or have another health plan) and indicated on your HSA Eligibility Questionnaire that you would like to be enrolled in an HRA if you become ineligible for an HSA, we will administer and provide you with an HRA instead. You must notify us that you are ineligible for an HSA. Coverage under the HRA will be effective the later of the date you lose HSA eligibility or the date you notify us of your change in eligibility.

In 2009, we will give you an HRA credit of \$900 per year for self only enrollment and \$1,800 per year for a self and family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

**HRA features include:**

- Your HRA is administered by Blue Healthcare Bank
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
- Tax-free credit can be used to pay for Qualified Medical Expenses (as defined in Section 8 of this Addendum) for you, your spouse, and your dependents (see IRS publication 502 for a complete list of Qualified Medical Expenses)
- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans
- An HRA does not affect your ability to participate in an HCFSAs, such as FSAFEDS; however, you must meet FSAFEDS eligibility requirements. (See Section 12 of the Service Benefit Plan brochure, under the Federal Flexible Spending Account Program – *FSAFEDS*.)

**Deductible and catastrophic protection for out-of-pocket expenses**

The Basic Consumer Option catastrophic maximum is the same as the calendar year deductible; once you reach the calendar year deductible, you will not have additional out-of-pocket expenses for covered medical services. When you use Preferred providers, your annual maximum for out-of-pocket expenses for covered services is limited to \$2,900 for self only coverage and \$5,800 for self and family coverage. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). For more details, please refer to Section 6 of this Addendum (relating to your catastrophic protection out-of-pocket maximum) and Section 4 of the Service Benefit Plan brochure.

**Health education resources and account management tools**

Section 7 of this Addendum describes the health education resources and account management tools available to help you manage your health care and your health care dollars.

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## Section 2. How we change for 2009

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Do not rely only on these change descriptions; this Section is not an official statement of benefits nor a list of all language changes to this Addendum. To see Basic Option benefit changes that apply to the Basic Consumer Option, refer to the summary appearing on pages 9 and 10 of the Service Benefit Plan brochure. See Section 5 (Benefits) of the Service Benefit Plan brochure for complete benefit descriptions.

### Changes to our Basic Consumer Option

- Your HSA Effective Date is now defined as the date that funds are deposited into your account, either by you or by the Plan. Previously, the HSA Effective Date was the later of the HSA Eligibility Date or HSA Established Date. (See pages 14 and 27.)
- Blue Healthcare Bank is now located at P.O. Box 610, Williamsville, NY 14231. Blue Healthcare Bank's email address, phone number, and fax number remain the same. (See page 6.)
- Health Reimbursement Arrangements (HRAs) no longer have any associated fees. Previously, there were fees for additional forms and printed statements. (See page 7.)
- You are now eligible for Basic Consumer Option even if you have received disregarded coverage (see *Definitions*) and/or preventive care from the Department of Veteran Affairs (VA) in the previous three months. Previously, individuals who received any type of VA benefits in the past three months were ineligible. (See page 7.)
- The annual HSA contribution limit is now \$3,000 for individuals and \$5,950 for families. Previously, the contribution limit was \$2,900 for individuals and \$5,800 for families. (See page 9.)
- Contributions made by Basic Consumer Option on your behalf during 2009 will be forfeited if you do not open your HSA by the end of February 2010. Previously, there was no provision for forfeiting contributions if an individual's account had not been opened. (See page 12.)
- The "catch-up" contribution limit for people age 55 or older is now \$1,000. Previously, this limit was \$900. (See page 14.)

### Section 3. Savings – HSAs and HRAs

	<p><b>Important things you should keep in mind about these benefits:</b></p> <ul style="list-style-type: none"> <li>• Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs) are governed by the Internal Revenue Code (IRC). It is very important that you understand and follow all such rules in order to protect the tax-free status of your accounts.</li> <li>• Your HSA will not be established until you return all of your paperwork. It is very important to return the paperwork promptly because you may not submit claims for covered expenses that are incurred before your account is established and funds are deposited. It is also important to return your paperwork promptly if you're electing an HRA.</li> <li>• If your Basic Consumer Option is effective the first payroll date in January 2009, and that date is after January 1, 2009, you will not be able to use your HSA until February 1, 2009. See page 14 of this Addendum for more information.</li> <li>• The IRC governs when you are eligible for an HSA. Please review a summary of those rules carefully (see pages 7 and 8 of this Addendum). Also, if you enroll in the HSA and you become ineligible during the year, it is important to notify us promptly or you could have negative tax consequences.</li> <li>• If you choose to contribute more to an HSA than the amount we will transfer from your Basic Consumer Option premium, you will need to carefully review the IRS rules regarding annual contribution limits to calculate the additional amount you may contribute.</li> <li>• In order to protect the tax-free status of HRA or HSA reimbursements, it is very important that you keep copies of your medical receipts.</li> </ul>	
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<b>Feature Comparison</b>	<b>Health Savings Account (HSA)</b>	<b>Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA</b>
<b>Administrator</b>	<p>The Plan will establish an HSA for you with Blue Healthcare Bank, this HDHP's qualified HSA trustee or custodian. Before your account can be opened and ready to use, you must complete all of the steps described under <i>Availability of funds</i> on page 12.</p> <p>Blue Healthcare Bank P.O. Box 610 Williamsville, NY 14231</p> <p>Email address: info@bluehealthcarebank.com</p> <p>Fax number: 1-800-207-3019</p>	<p>Blue Healthcare Bank is the HRA custodian for this Plan.</p> <p>Blue Healthcare Bank P.O. Box 610 Williamsville, NY 14231</p> <p>Email address: info@bluehealthcarebank.com</p> <p>Fax number: 1-800-207-3019</p>

<b>Feature Comparison</b>	<b>Health Savings Account (HSA)</b>	<b>Health Reimbursement Arrangement (HRA)</b>
<b>Fees</b>	<p>Set-up and monthly maintenance fees are paid by the HDHP.</p> <p>Enrollees will be responsible for the following fees as applicable. Fees are subject to change; the most recent fee list is available through <a href="http://www.fepblue.org">www.fepblue.org</a>:</p> <ul style="list-style-type: none"> <li>• \$20 excess contribution fee</li> <li>• \$5 debit card reorder fee and additional debit card order fee</li> <li>• \$6 fee for 25 checks and 10 deposit slips (3 starter checks free)</li> <li>• \$1.75 monthly service fee for investment account</li> <li>• \$25 merchant debit card fee</li> <li>• \$20 overdraft fee</li> <li>• \$10 uncollected funds fee</li> <li>• \$15 wire transfer fee</li> <li>• \$5 mailing additional form fee</li> <li>• \$5 monthly statement reprint fee</li> <li>• \$15 account closure fee</li> <li>• \$15 stop payment fee</li> <li>• \$2 check copy fee</li> <li>• \$30/hour for research/subpoena fee</li> <li>• \$5 original item retrieval fee</li> <li>• \$4 manual check distribution fee</li> <li>• \$20 rush card request fee</li> </ul>	N/A
<b>Eligibility</b>	<p>You must:</p> <ul style="list-style-type: none"> <li>• Enroll in the Basic Consumer Option</li> <li>• Have no other health insurance coverage [does not apply to specific injury, accident, disability, dental, vision, or long-term care coverage, or to another HSA-qualified High Deductible Health Plan (HDHP)]</li> <li>• Not be enrolled in Medicare</li> <li>• Not be claimed as a dependent on someone else's tax return</li> <li>• Not have received VA benefits in the previous three months, with the exception of disregarded coverage (see <i>Definitions</i>) and/or preventive care</li> <li>• Complete and return all paperwork (e.g., HSA Eligibility Questionnaire and bank documents)</li> </ul>	<p>You must:</p> <ul style="list-style-type: none"> <li>• Enroll in the Basic Consumer Option</li> <li>• Complete and return all paperwork (e.g., HSA Eligibility Questionnaire)</li> </ul> <p>Your HRA will be effective the same day coverage under the Basic Consumer Option is effective. If you enroll after Open Season, your employer credit will be prorated based on your date of enrollment.</p>

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
<p><b>Change in eligibility</b></p>	<p>You must notify us right away if any of the following occurs:</p> <ul style="list-style-type: none"> <li>• You become enrolled in Medicare.</li> <li>• You become enrolled in TRICARE.</li> <li>• You establish a health care flexible spending account (FSA) that is not a limited expense FSA.</li> <li>• Your spouse establishes a health care flexible spending account (FSA) that is not a limited expense FSA.</li> <li>• You become covered under other health insurance coverage that is not an HSA-qualified HDHP.</li> <li>• You receive VA medical benefits.</li> <li>• You become eligible to be claimed as a dependent on someone else's federal tax return.</li> </ul> <p><i>A delay in notifying us about any of these events could result in negative tax consequences for you.</i></p> <p>If you lose eligibility and indicated on your HSA Eligibility Questionnaire that you would like to be enrolled in an HRA if you become ineligible for an HSA, we will enroll you in an HRA. Your HRA will be effective the later of the date you lose HSA eligibility or the date you notify us of your change in eligibility. You will be eligible for HRA contributions prorated as if you were a new hire.</p>	<p>If you are enrolled in an HRA and become newly eligible for an HSA mid-year, you will not be eligible to change to an HSA right away. You must wait until Open Season to change from an HRA to an HSA.</p>
<p><b>Funding</b></p>	<p>If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited into your HSA each month. Premium Pass Through contributions are based on the effective date of your enrollment in the HDHP.</p> <p>In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).</p>	<p>Eligibility for the annual credit will be determined by your Basic Consumer Option Effective Date, and the amount of your credit will be prorated based on the number of months between your effective date and the end of the year.</p> <p>If you leave the Basic Consumer Option or service with the Federal government and are rehired within the same year, your annual credit less any reimbursed claims will be reinstated.</p>
<ul style="list-style-type: none"> <li>• <b>Self Only enrollment</b></li> </ul>	<p>For 2009, a monthly Premium Pass Through of \$75 will be made directly into your HSA for each month that you are eligible.</p>	<p>For 2009, your HRA annual credit is \$900 (prorated for mid-year enrollees).</p>
<ul style="list-style-type: none"> <li>• <b>Self and Family enrollment</b></li> </ul>	<p>For 2009, a monthly Premium Pass Through of \$150 will be made directly into your HSA for each month that you are eligible.</p>	<p>For 2009, your HRA annual credit is \$1,800 (prorated for mid-year enrollees).</p>

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
<p><b>Contributions/credits</b></p>	<p>The maximum that can be contributed to your HSA is an annual combination of HDHP Premium Pass Through and enrollee contribution funds, which when combined do not exceed the maximum contribution limit set by the IRS each year, which is \$3,000 for individuals or \$5,950 for families in 2009. To determine the amount you may contribute, calculate the annual limit based on your number of months of eligibility and subtract the amount the Plan will contribute to your account for the year.</p> <p>Under a special rule for individuals with partial year HDHP coverage, you are eligible to contribute up to the total IRS limit even if you are only enrolled in your HDHP for part of the year so long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. (For example, if you are a new hire and enroll in the Basic Consumer Option effective June 1, 2009, you would need to remain in an HSA-qualified HDHP until December 31, 2010, in order to contribute the maximum 2009 amount on a tax-free basis.) If you take advantage of this special rule and do not remain enrolled in your HDHP for 12 months from the end of the year, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.</p> <p>If you don't take advantage of the special rule for individuals with partial year HDHP coverage, for each month that you are not eligible to contribute to an HSA, your maximum contribution amount is reduced by 1/12.</p> <p>Depending on how your payroll works, your HDHP may not take effect until the first pay period in January 2009. IRS rules require you to have an HDHP on the first of the month in order to make an HSA contribution for that month. If your HDHP takes effect January 8, 2009, for example, you will not be eligible to make an HSA contribution until February 1, 2009. Therefore, your annual contribution limit for your first year in the program will be 11/12th of the annual 2009 limit set forth by the IRS.</p>	<p>The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.</p>

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
	<p>Individuals who enroll during Open Season and have a Basic Consumer Option Effective Date of January 1 will generally be eligible to make the full 12 months of contributions.</p> <ul style="list-style-type: none"> <li>• To determine the amount of money you're allowed to contribute in addition to the HSA Premium Pass Through contributed by the Plan, take the annual IRS limit (indexed for inflation) divided by 12, times the number of full months enrolled in the Basic Consumer Option. Subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution to determine the amount you may contribute.</li> <li>• You may rollover funds you have in other HSAs to your HSA with Blue Healthcare Bank (rollover funds do not affect the annual maximum contribution).</li> <li>• HSAs earn tax-free interest (does not affect your annual maximum contribution). For information on the current interest rates, please visit <a href="http://www.fepblue.org">www.fepblue.org</a>.</li> <li>• You may also be able to make catch-up contributions, which are discussed on page 14 of this Addendum.</li> </ul> <p>For more information regarding the contribution limits, refer to page 14 of this Addendum.</p>	
<ul style="list-style-type: none"> <li>• <b>Self Only enrollment</b></li> </ul>	<p>If your HDHP is effective January 1, you may make an annual contribution of \$2,100.</p> <p>If your HDHP is effective on another date during the month of January, you may make an annual contribution of \$1,850.</p>	<p>You cannot contribute to an HRA.</p>
<ul style="list-style-type: none"> <li>• <b>Self and Family enrollment</b></li> </ul>	<p>If your HDHP is effective January 1, you may make an annual contribution of \$4,150.</p> <p>If your HDHP is effective on another date during the month of January, you may make an annual contribution of \$3,655.</p>	<p>You cannot contribute to an HRA.</p>

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
<b>Accessing funds</b>	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> <li>• Check</li> <li>• Debit card</li> <li>• Withdrawal form</li> <li>• Online bill payment</li> </ul>	<p>To be reimbursed for Qualified Medical Expenses, you must submit a reimbursement form to Blue Healthcare Bank. HRA reimbursement request forms are available online through <a href="http://www.fepblue.org">www.fepblue.org</a>, or by contacting customer service at Blue Healthcare Bank.</p> <p>Questions regarding a denied claim for HRA reimbursement should be sent to Blue Healthcare Bank. Further information will be provided to you on the HRA Explanation of Benefits Statement you will receive notifying you of a denied claim.</p>
<b>When you receive services</b>	<p>Just like Basic Option, a Preferred provider will submit your claim for payment and then send you a bill.</p>	<p>Just like Basic Option, a Preferred provider will submit your claim for payment and then send you a bill.</p>
<b>Distributions/withdrawals</b> <ul style="list-style-type: none"> <li>• <b>Medical</b></li> </ul>	<p>You can pay the out-of-pocket expenses for yourself, your spouse, or your dependents (even if they are not covered by the Basic Consumer Option) from the funds available in your HSA.</p> <p>You may not submit claims for covered expenses that are incurred before your account is effective, as defined in Section 8 of this Addendum.</p> <ul style="list-style-type: none"> <li>• See IRS Publication 502 for a list of eligible medical expenses, including over-the-counter drugs.</li> </ul>	<p>You can pay the out-of-pocket expenses for Qualified Medical Expenses for individuals covered under the HDHP.</p> <p>Non-reimbursed Qualified Medical Expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> on the next page for information on when funds are available in the HRA.</p> <p>See IRS Publication 502 for a list of eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.</p>
<ul style="list-style-type: none"> <li>• <b>Non-medical</b></li> </ul>	<p>If you are under age 65, withdrawal of funds for non-Qualified Medical Expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.</p> <p>When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty, however they will be subject to ordinary income tax.</p>	<p>Not applicable – distributions will not be made for anything other than non-reimbursed Qualified Medical Expenses.</p>

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)
<b>Availability of funds</b>	<p>Funds are not available for withdrawal until all of the following steps are completed:</p> <p><b>Step 1:</b> Your enrollment in this HDHP is effective (effective date is determined by your agency in accordance with the event permitting the enrollment change).</p> <p><b>Step 2:</b> You complete and return an HSA Eligibility Questionnaire that you will receive from the Plan to establish your eligibility for an HSA versus an HRA.</p> <p><b>Step 3:</b> You complete and return the paperwork you will receive from Blue Healthcare Bank in order to establish (or open) your HSA.</p> <p><i>Note that it is very important to complete all of your HSA paperwork as soon as possible because you cannot be reimbursed on a tax-free basis for claims incurred before your HSA Effective Date. Further, if you do not open your HSA before February 28, 2010, you will forfeit all contributions Basic Consumer Option would have made on your behalf for 2009.</i></p> <p>Your HSA Effective Date is the date on which the initial funds are deposited (either by the member or by the Plan). See page 14 of the Addendum for more information.</p>	<p>The entire amount of your HRA credit will be available to you upon your enrollment in the HDHP. <b>Note:</b> You must complete and return an HSA Eligibility Questionnaire, and indicate that you would like to be enrolled in an HRA, before your HRA can be established.</p>
<b>Account owner</b>	FEHB enrollee	Blue Cross and Blue Shield Service Benefit Plan Basic Consumer Option
<b>Portability</b>	<p>You can take this account with you when you change plans, separate, or retire. As an annuitant, you may be able to continue participating in the Basic Consumer Option and your HSA. See page 3.</p> <p>After you change plans or separate from service, the Plan will no longer make Premium Pass Through contributions to your account. If you do not enroll in another HDHP, you can no longer contribute to your HSA. Even if you do not remain covered by an HDHP, you may continue to spend any balance available in your HSA.</p>	<p>If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.</p> <p>If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Claims must be submitted by December 31 following the year the claim was incurred. See Section 7 of the Service Benefit Plan brochure for more information about claim filing requirements.</p> <p>Unused funds are forfeited.</p>
<b>Annual rollover</b>	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

<b>Feature Comparison</b>	<b>Health Savings Account (HSA)</b>	<b>Health Reimbursement Arrangement (HRA)</b>
<b>Flexible Spending Accounts (FSAs)</b>	<p>If you are enrolled in the Basic Consumer Option with an HSA and start or become covered by a health care Flexible Spending Account (such as FSAFEDS offers – see Section 12 of the Service Benefit Plan brochure), no contributions can be made to your HSA. Similarly, no contributions can be made to an HSA if your spouse enrolls in a health care Flexible Spending Account (FSA).</p> <p>However, a Limited Expense Health Care Flexible Spending Account (LEX HCFSA) is a savings option that is available to employees who are enrolled in an HSA. Dental and vision care costs (for services/products that meet the IRS definition of medical care) are the only reimbursable expenses covered under the LEX HCFSA. For more information, see Section 12 of the Service Benefit Plan brochure.</p>	<p>If you are enrolled in an HRA, you are eligible to participate in the FSAFEDS health care Flexible Spending Account. See Section 12 of the Service Benefit Plan brochure. You must first submit any eligible expenses to your HCFSA. If there is no HCFSA balance available, you may submit claims to be reimbursed from your HRA.</p>

## If you have an HSA

- **HSA Effective Date** Your HSA Effective Date is the date on which the initial funds are deposited (either by the member or by the Plan). The date on which you are first eligible to deposit funds is the later of the HSA Eligibility Date and the HSA Established Date.  
  
Your agency will determine your effective date in the Basic Consumer Option.  
  
Your HSA is effective for use on a tax-free basis for health care services incurred on or after the HSA Effective Date. For examples illustrating how your Effective Date is determined, please visit [www.fepblue.org](http://www.fepblue.org).  
  
***NOTE: It is very important to complete all of your HSA paperwork as soon as possible.***
- **Contributions** All contributions are aggregated and cannot exceed the annual maximum contribution. You may contribute your own money to your HSA account through payroll deductions (if available), or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages even if you do not contribute your own money. You have until April 15 of the following year to make HSA contributions for the current year.  
  
You may contribute the difference between the Plan's Premium Pass Through contribution and the statutory limit for your type of coverage (self only or self and family) to the HSA. The annual maximum contribution is established by law and adjusted each year. Your contribution limit is calculated per month and is based on the number of months in which you had HSA-qualified HDHP coverage *as of the first day of the month*. If, under the rules established by your agency, your Basic Consumer Option will take effect January 8, 2009, you will not be eligible to make an HSA contribution until February 1, 2009.  
  
For examples illustrating how this works, please visit [www.fepblue.org](http://www.fepblue.org).
- **Catch-up contributions** If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. In 2009, you may contribute up to \$1000 in catch-up contributions. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site through [www.ustreas.gov/offices/public-affairs/hsa/](http://www.ustreas.gov/offices/public-affairs/hsa/).

- **Excess contributions** If total contributions to your HSA for a year are more than the annual maximum allowed by the IRS, you may avoid paying a 6% excise tax penalty if you withdraw the funds by April 15 of the following year. Blue Healthcare Bank does charge a fee for excess contributions. It is your responsibility to monitor the contributions to your HSA and ensure you are in compliance with the Federal rules that allow for the tax-free status of the HSA.
- **If you die** If you do not have a named beneficiary, and you are married, it becomes your spouse's HSA; otherwise, it becomes part of your taxable estate.
- **Qualified expenses** You can pay for "Qualified Medical Expenses" as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, over-the-counter drugs, LASIK surgery, and some nursing services.

When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

For a detailed list of IRS-allowed expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Web site at [www.irs.gov](http://www.irs.gov) and click on "Forms and Publications." **Note:** Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

*Tip: Be sure to keep your receipts and medical records. If you have an HRA, you will need to submit these documents in order to receive reimbursement. If you have an HSA, you will need to keep these records to verify that you paid Qualified Medical Expenses using your HSA, which you need to report when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay Qualified Medical Expenses, you may need to report the distribution as taxable income on your tax return. The IRS may also request receipts during a tax audit.*

*Neither the Plan nor Blue Healthcare Bank will verify that distributions from your HSA are for Qualified Medical Expenses. Consult your tax advisor to determine how your HSA affects your unique tax situation.*
- **Non-qualified expenses** You may withdraw money from your HSA for items other than Qualified Medical Expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- **Tracking your HSA balance** You will receive a monthly statement that shows the Premium Pass Through, withdrawals, and interest earned on your account.
- **Minimum reimbursements from your HSA** You can request reimbursement in any amount. Just like a normal bank account, you cannot reimburse yourself for expenses that are greater than the balance in the account.

## **If you have an HRA**

- **Why an HRA is established**

If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, and indicated on your HSA Eligibility Questionnaire that you would like to be enrolled in an HRA if you become ineligible for an HSA, we will establish an HRA for you.

You must promptly tell us if you become ineligible to contribute to an HSA. Delay in notifying us could result in negative tax consequences for you. For more information, see *Change in eligibility* on page 8 of this Addendum.

If you leave the Plan or service with your employer and are rehired within the same year, your annual credit less any reimbursed claims will be reinstated.

- **How an HRA differs**

Please review the chart on pages 6-13 which details the differences between an HRA and an HSA. The major differences are:

- You cannot make contributions to an HRA.
- Funds are forfeited if you leave the HDHP.
- An HRA does not earn interest.
- HRAs can only pay for Qualified Medical Expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered under your Basic Consumer Option coverage.
- For the HRA, FEHB law does not permit Qualified Medical Expenses to include services, drugs, or supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.

## Section 4. Preventive Care

	<p><b>Important things you should keep in mind about these benefits:</b></p> <ul style="list-style-type: none"> <li>• Please remember that all benefits are subject to the definitions, limitations, and exclusions in the Service Benefit Plan brochure and this Addendum and are payable only when we determine they are medically necessary.</li> <li>• You must use Preferred providers in order to receive benefits except as noted on page 14 of the Service Benefit Plan brochure.</li> <li>• The Plan pays 100% for preventive care services listed in this Section as long as you use a Preferred provider. For benefits for non-preventive care, please see Section 5 of this Addendum.</li> <li>• Services for Non-preferred providers (either Participating or Non-participating) may be covered under certain circumstances. See the exceptions listed on page 14 of the Service Benefit Plan brochure. Page 24 of this Addendum provides information on how charges from Non-preferred providers accumulate toward the deductible and catastrophic protection maximum and what you may be required to pay above the Plan allowance.</li> <li>• Be sure to also read Section 9 of the Service Benefit Plan brochure about coordinating benefits with other coverage.</li> </ul>	
Benefits Description	You pay (not subject to the deductible)	
<b>Preventive care, adult</b>		
Services are covered as they are under Basic Option. See pages 32-34 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges (except as noted on pages 32-34 of the Service Benefit Plan brochure)	
<b>Preventive care, children</b>		
Services are covered as they are under Basic Option. See page 34 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges (except as noted on page 34 of the Service Benefit Plan brochure)	

## Section 5. Traditional Medical Coverage Subject to the Deductible

	<p><b>Important things you should keep in mind about these benefits:</b></p> <ul style="list-style-type: none"> <li>• Please remember that all benefits are subject to the definitions, limitations, and exclusions in the Service Benefit Plan brochure and this Addendum and are payable only when we determine they are medically necessary.</li> <li>• The deductible is \$2,900 for self-only enrollment or \$5,800 for self and family enrollment. The family deductible can be satisfied by one or more family members. You must pay your deductible before your traditional medical coverage begins.</li> <li>• You are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. The Basic Consumer Option catastrophic protection benefit is set to the same level as the calendar year deductible so once you reach that level of out-of-pocket expenses, you will not have additional out-of-pocket expenses for covered medical services from Preferred providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s allowable amount or benefit maximum).</li> <li>• You must use Preferred providers in order to receive benefits except as noted on page 14 of the Service Benefit Plan brochure.</li> <li>• Once you have satisfied your deductible, the Basic Consumer Option pays 100% of the Plan allowance for the traditional medical services summarized in this Section. See Section 5 of the Service Benefit Plan brochure for detailed benefit information. For information about our benefits for preventive care, see Section 4 of this Addendum.</li> <li>• Services for Non-preferred providers (either Participating or Non-participating) may be covered under certain circumstances. See the exceptions listed on page 14 of the Service Benefit Plan brochure. Page 24 of this Addendum provides information on how charges from Non-preferred providers accumulate toward the deductible and catastrophic protection maximum and what you may be required to pay above the Plan allowance.</li> <li>• Be sure to also read Section 9 of the Service Benefit Plan brochure about coordinating benefits with other coverage.</li> </ul>	
<b>Benefits Description</b>		<b>You Pay 100% of Plan allowance (for Preferred providers) until deductible and catastrophic maximum are met</b>
<b>Medical services and supplies provided by physicians and other health care professionals</b>		
<b>Diagnostic and treatment services</b>		
Services are covered as they are under Basic Option. See pages 29-31 of the Service Benefit Plan brochure.		Preferred: You pay nothing Participating/Non-participating: You pay all charges
<b>Lab, X-ray, and other diagnostic tests</b>		
Services are covered as they are under Basic Option. See page 31 of the Service Benefit Plan brochure.		Preferred: You pay nothing Participating/Non-participating: You pay all charges (except as noted on page 31 of the Service Benefit Plan brochure)

<b>Benefits Description</b>	<b>You Pay 100% of Plan allowance (for Preferred providers) until deductible and catastrophic maximum are met</b>
<b>Maternity care</b>	
Services are covered as they are under Basic Option. See pages 35-36 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges (except as noted on page 35 of the Service Benefit Plan brochure)
<b>Family planning</b>	
Services are covered as they are under Basic Option. See page 37 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges
<b>Infertility services</b>	
Services are covered as they are under Basic Option. See pages 37-38 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges (except as noted on page 37 of the Service Benefit Plan brochure)
<b>Allergy care</b>	
Services are covered as they are under Basic Option. See page 38 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges (except as noted on page 38 of the Service Benefit Plan brochure)
<b>Treatment therapies</b>	
Services are covered as they are under Basic Option. See page 39 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges
<b>Physical therapy, occupational therapy, speech therapy, and cognitive therapy</b>	
Services are covered as they are under Basic Option. See page 40 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges <i>Note:</i> See page 40 of the Service Benefit Plan brochure for applicable benefit limits.

<b>Benefits Description</b>	<b>You Pay 100% of Plan allowance (for Preferred providers) until deductible and catastrophic maximum are met</b>
<b>Hearing services (testing, treatment, and supplies)</b>	
Services are covered as they are under Basic Option. See page 41 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges <i>Note:</i> See page 41 of the Service Benefit Plan brochure for applicable benefit limits.
<b>Vision services (testing, treatment, and supplies)</b>	
Services are covered as they are under Basic Option. See pages 41-42 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges
<b>Foot care</b>	
Services are covered as they are under Basic Option. See page 42 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges
<b>Orthopedic and prosthetic devices</b>	
Services are covered as they are under Basic Option. See pages 43-44 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges
<b>Durable medical equipment (DME)</b>	
Services are covered as they are under Basic Option. See pages 45-46 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges
<b>Medical supplies</b>	
Services are covered as they are under Basic Option. See page 47 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges
<b>Home health services</b>	
Services are covered as they are under Basic Option. See pages 47-48 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges
<b>Chiropractic</b>	
Services are covered as they are under Basic Option. See page 48 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges <i>Note:</i> See page 48 of the Service Benefit Plan brochure for applicable benefit limits.

<b>Benefits Description</b>	<b>You Pay 100% of Plan allowance (for Preferred providers) until deductible and catastrophic maximum are met</b>
<b>Alternative treatments</b>	
Services are covered as they are under Basic Option. See page 49 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges <i>Note:</i> See page 49 of the Service Benefit Plan brochure for applicable benefit limits.
<b>Educational classes and programs</b>	
Services are covered as they are under Basic Option. See page 50 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges
<p><b>Surgical and anesthesia services provided by physicians and other health care professionals</b></p> <p><i>Note: YOU MUST GET PRIOR APPROVAL for the following surgical services if they are to be performed on an outpatient basis: surgery for morbid obesity; surgical correction of congenital anomalies; and surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth.</i> Please refer to page 16 of the Service Benefit Plan brochure for more information.</p> <p><i>Note: YOU MUST GET PRIOR APPROVAL for all organ transplant surgical procedures (except kidney and cornea transplants); and if your surgical procedure requires an inpatient admission, YOU MUST GET PRECERTIFICATION.</i> Please refer to the prior approval and precertification information shown in Section 3 of the Service Benefit Plan brochure to be sure which services require prior approval or precertification.</p>	
<b>Surgical procedures</b>	
Services are covered as they are under Basic Option. See pages 52-53 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges
<b>Reconstructive surgery</b>	
Services are covered as they are under Basic Option. See page 54 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges
<b>Oral and maxillofacial surgery</b>	
Services are covered as they are under Basic Option. See page 55 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges
<b>Organ/tissue transplants</b>	
Services are covered as they are under Basic Option. See pages 56-63 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges

<b>Benefits Description</b>	<b>You Pay 100% of Plan allowance (for Preferred providers) until deductible and catastrophic maximum are met</b>
<b>Anesthesia</b>	
Services are covered as they are under Basic Option. See page 64 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges
<b>Services provided by a hospital or other facility, and ambulance services</b> <i>Note: YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY.</i> For more information see the precertification information in Section 3 of the Service Benefit Plan brochure.	
<b>Inpatient hospital</b>	
Services are covered as they are under Basic Option. See pages 66-68 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges
<b>Outpatient hospital or ambulatory surgical center</b>	
Services are covered as they are under Basic Option. See pages 69-71 of the Service Benefit Plan brochure.	Preferred: You pay nothing Member/Non-member: You pay all charges (except as noted on pages 69-71 of the Service Benefit Plan brochure)
<b>Extended care benefits/Skilled nursing care facility benefits</b>	
Services are covered as they are under Basic Option. See page 72 of the Service Benefit Plan brochure.	You pay all charges
<b>Hospice care</b>	
Services are covered as they are under Basic Option. See pages 73-74 of the Service Benefit Plan brochure. <i>Note: Hospice care requires prior approval.</i> See page 74 of the Service Benefit Plan brochure for more information.	Hospice care generally: You pay nothing Inpatient hospice: Preferred: You pay nothing Member/Non-member: You pay all charges
<b>Ambulance</b>	
Services are covered as they are under Basic Option. See page 75 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Member or Non-participating/Non-member: You pay nothing

<b>Benefits Description</b>	<b>You Pay 100% of Plan allowance (for Preferred providers) until deductible and catastrophic maximum are met</b>
<b>Emergency services/accidents</b>	
<b>Accidental injury</b>	
Services are covered as they are under Basic Option. See pages 77-78 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Member or Non-participating/Non-member: You pay all charges (except as noted on pages 77-78 of the Service Benefit Plan brochure)
<b>Medical emergency</b>	
Services are covered as they are under Basic Option. See pages 79-80 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges (except as noted on page 79 of the Service Benefit Plan brochure)
<b>Ambulance</b>	
Services are covered as they are under Basic Option. See page 80 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Member or Non-participating/Non-member: You pay nothing
<b>Other benefits</b>	
<b>Mental health and substance abuse benefits</b>	
Services are covered as they are under Basic Option. See pages 81-87 of the Service Benefit Plan brochure. <b>Note: You must get prior approval for all mental health and substance abuse services, as well as inpatient hospital stays.</b> For more information see Section 5(e) of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Member or Non-participating/Non-member: You pay all charges (except as noted on pages 81-87 of the Service Benefit Plan brochure)
<b>Prescription drug benefits</b>	
Services are covered as they are under Basic Option. See pages 90-95 of the Service Benefit Plan brochure. <b>Note: You must get prior approval for certain prescription drugs.</b> For more information see Section 5(f) of the Service Benefit Plan brochure.	Preferred retail pharmacy: You pay nothing Non-preferred retail pharmacy: You pay all charges Mail service: No benefit
<b>Dental benefits</b>	
Services are covered as they are under Basic Option. See pages 96 and 101 of the Service Benefit Plan brochure.	Preferred: You pay nothing Participating/Non-participating: You pay all charges

## Section 6. Deductible and Catastrophic Protection

<b>Lifetime Maximum</b>	Not Applicable
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	Preferred Providers	Non-preferred Providers
<b>Annual Deductible</b> (Except Preventive Services)	Self: \$2,900 Self and Family: \$5,800	Self: N/A – in-network only Self and Family: N/A – in-network only
<b>Annual Catastrophic Protection Maximum</b> (Stop loss)	Self: \$2,900 Self and Family: \$5,800	Self: N/A Self and Family: N/A

You are responsible for paying 100% of the Plan allowance for covered services until you reach your annual calendar year deductible and your annual calendar year catastrophic protection maximum. The Basic Consumer Option catastrophic protection maximum is the same as the calendar year deductible; so once you reach the calendar year deductible, you will not have additional out-of-pocket expenses for covered medical services.

Your annual maximum for out-of-pocket expenses for covered services is limited to \$2,900 for self only contracts and \$5,800 for self and family contracts. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s allowable amount or benefit maximum). Refer to Section 4 of the Blue Cross and Blue Shield Service Benefit Plan brochure for more details.

### **Change in Benefit Option**

As a general rule, once you make an election to participate in any of the benefit Options offered by the Service Benefit Plan, you may not change your election until the next year’s open enrollment. However, you may sometimes change an election mid-year when you have certain Qualifying Life Events. Check with your agency if you have any questions about changes to your enrollment.

If you transfer from the Basic Consumer Option to the Basic or Standard Option sometime during the year or vice versa, you will receive credit for your deductible or catastrophic protection maximums that you had accumulated under your original plan during that calendar year. Similarly, any of your annual calendar year benefit maximums (such as visit or day limits) accumulated under the original plan will be applied to the new plan.

### **Preferred and Non-preferred Providers**

Typically, we pay 100% of the Plan allowance for services from Preferred providers. Just like under Basic Option, you must use Preferred providers in order to receive benefits from the medical plan. You may be able to reimburse yourself from the HSA or HRA for using a Non-preferred provider. However, claims for benefits from Non-preferred providers will not count toward the deductible or catastrophic protection maximum and will not be paid once you have reached your deductible and catastrophic protection maximum.

Sometimes we will pay for benefits for Non-preferred providers. See page 14 of the Service Benefit Plan brochure for exceptions to this requirement. For information about the benefits paid for services by Non-preferred providers, see Section 5 of the Service Benefit Plan brochure.

If you receive services from a Non-preferred provider when an exception is warranted, the Plan allowance will accumulate toward the deductible and catastrophic protection maximum. (However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum, such as expenses in excess of the Plan's allowable amount or benefit maximum.) Once you have reached your deductible and catastrophic maximum:

- Participating/Member providers: Services will be paid (up to the Plan allowance) and you will not have to pay any more.
- Non-participating/Non-member providers:
  - Generally: The Plan will pay up to the Plan allowance. If the provider charges more than the Plan allowance, you must pay the difference.

**EXAMPLE:** If you are in a Preferred hospital and receive services from a Non-participating radiologist who charges \$500 for his/her services when the Plan allowance (or Non-participating Provider Allowance, NPA) is \$400, we will accumulate \$400 toward the deductible and catastrophic protection maximum. You will have to pay for the full \$500 bill. If you met your deductible and catastrophic protection maximum, we would then pay \$400 and you would be responsible for the amount over the NPA, or \$100.

- If you qualify for a “special provider access situation”: The Plan will pay all charges from the Non-participating provider.

### **Pharmaceutical benefits**

Generally, the Plan allowance for pharmaceutical benefits is the Average Wholesale Price (AWP) minus any discounts. It is that amount, the Plan allowance, that will accumulate toward your deductible and catastrophic maximum.

### **Prior approval**

Enrollees and family members who do not have prior approval for the drugs or services that require prior approval will not have amounts credited to the deductible or catastrophic protection maximum, nor will they be reimbursed for expenses if they have met their deductible and catastrophic maximum. For more information, refer to Section 3 of the Service Benefit Plan brochure.

### **Coordination of benefits with Medicare**

If you are covered by Medicare and are enrolled in the Basic Consumer Option, you are eligible only for an HRA. We will not waive any deductibles or member cost sharing in the Basic Consumer Option. You still will need to meet your calendar year deductible (and catastrophic protection maximum) before we will pay benefits.

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## Section 7. Health Education Resources and Account Management Tools

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### Health Education Resources

When you enroll in Basic Consumer Option, you will have available to you a variety of health education resources.

Stay connected to your health and get the answers you need when you need them by using Blue Health Connection 24 hours a day, 365 days a year. This service offers you direct communication with a Registered Nurse by calling 1-888-258-3432 toll-free, or by accessing our Web site, [www.fepblue.org](http://www.fepblue.org). Blue Health Connection provides one-stop shopping for health information and health care management. You can check your symptoms with the Symptoms Checker, read information about healthy eating and weight loss, and listen to a range of health-related topics from the AudioHealth Library.

Starting in 2009, Blue Health Connection will also offer an online Health Assessment. This quick online tool will help you look at your personal health, review your family history, and obtain personalized suggestions about health-related behaviors to improve or maintain your health and wellness. Please keep in mind that benefits for any health care services you may seek after using Blue Health Connection are subject to the terms of your coverage under this Plan.

### Account Management Tools

Blue Healthcare Bank offers an account management portal where you can keep track of your account balances, transactions, allocations, and contributions. For enrollees with HSAs, you can use the internet banking features of Blue Healthcare Bank to transfer funds and for online bill paying. For more information, visit [www.fepblue.org](http://www.fepblue.org).

For each HSA and HRA account holder, we maintain a complete claims payment history online through [www.fepblue.org](http://www.fepblue.org).

If you have an **HSA**:

- You will receive a statement outlining your account balance and activity for the month
- Your HSA balance and other account information will be available online through [www.fepblue.org](http://www.fepblue.org)

If you have an **HRA**:

- You will receive a statement outlining your account balance and activity for the month
- Your HRA balance will be available online through [www.fepblue.org](http://www.fepblue.org)
- Your balance will also be shown on your HRA EOB form

### Consumer Choice Information

As a participant of this HDHP, you will receive discounts when you see a Preferred provider. (See page 24 of this Addendum for more information.)

Directories of providers are available online at [www.fepblue.org](http://www.fepblue.org).

Pricing information for medical care and for prescription drugs is available online through [www.fepblue.org](http://www.fepblue.org).

A link to the online pharmacy provider is available through [www.fepblue.org](http://www.fepblue.org).

Educational materials on the topics of HSAs, HRAs, and HDHPs are available through [www.opm.gov](http://www.opm.gov).

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## Section 8. Definitions

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The following are several definitions of terms specific to the Basic Consumer Option. Other terms are defined in the Service Benefit Plan brochure.

<b>Basic Consumer Option Effective Date</b>	The effective date of health care coverage under the Basic Consumer Option. If you are an active employee and enroll during Open Season, the Basic Consumer Option Plan Effective Date will be the first day of your first pay period that starts on or after January 1. Annuitants' coverage begins on January 1. For non-Open Season Enrollees, the payroll office will determine the Basic Consumer Option Effective Date based on the enrollment event.
<b>Catastrophic Protection Maximum (for out-of-pocket expenses)</b>	Your annual maximum for out-of-pocket expenses for covered services is limited to \$2,900 for self only contracts and \$5,800 for self and family contracts. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximums). Refer to Section 4 of the Service Benefit Plan brochure for more details.
<b>Disregarded coverage</b>	Disregarded coverage (IRS Notice 2004-38) includes "permitted insurance" and other specified coverage ("permitted coverage"). "Permitted insurance" is coverage under which substantially all of the coverage provided relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property, insurance for a specified disease or illness, and insurance that pays a fixed amount per day (or other period) of hospitalization. "Permitted coverage" (whether through insurance or otherwise) is coverage for accidents, disability, dental care, vision care, or long-term care. Prescription drug benefits are not listed as permitted insurance or as permitted coverage under section 223(c)(1)(B).
<b>Health Reimbursement Arrangement (HRA)</b>	Tax-free health plan deposits provided by us which allow you to accumulate savings for tax-free withdrawals for Qualified Medical Expenses including your health plan deductible and other qualified out-of-pocket expenses. HRA reimbursements for medical expenses are not included in an employee's income. Unused funds can be rolled over annually but are owned by the employer and thus are not portable when the employee leaves employment with the Federal government, changes FEP Options, or Health Plan carriers.
<b>Health Savings Account (HSA)</b>	A tax-exempt trust or custodial account established exclusively for the purpose of paying Qualified Medical Expenses of the account beneficiary who, for the months in which contributions are made to an HSA, is covered under a High Deductible Health Plan. An HSA is employee-owned but can be funded by the employer and/or the employee [maximum annual limits are established by the Internal Revenue Code (IRC)]. Unused funds are owned by the employee and thus are portable when the employee leaves the employer's company, changes Service Benefit Plan Options, or changes Health Plan carriers.
<b>High Deductible Health Plan (HDHP)</b>	An HDHP is a plan, such as Basic Consumer Option, providing medical and prescription drug benefits. The deductibles, which meet the requirements established by the IRC, make this plan eligible to coordinate with either an HSA or an HRA.
<b>HRA Effective Date</b>	The effective date of your enrollment in the Basic Consumer Option. Your HRA is effective for use on a tax-free basis for health care services incurred on or after this date. If you are provided an HRA during the year because you are no longer eligible for an HSA, your HRA will be effective the later of the date you lose HSA eligibility or the date you notify us of your change in eligibility.
<b>HSA Effective Date</b>	The date on which the initial funds are deposited (either by the member or by the Plan). The date on which you are first eligible to deposit funds is the later of the HSA Eligibility Date and the HSA Established Date. Your HSA is effective for use on a tax-free basis for health care services incurred on or after this date.
<b>HSA Eligibility Date</b>	The earliest date that you are eligible to have an HSA on a tax-free basis. This date is the first of the month following the Basic Consumer Option Effective Date, <i>except</i> when the Basic Consumer Option Effective Date falls on the first of the month. When the Basic Consumer Option Effective Date is the first of the month, the HSA Eligibility Date shall be the same date as the Basic Consumer Option Effective Date.

**HSA Eligibility Questionnaire**

The document you will receive in the mail with your ID card where you will determine eligibility to contribute to an HSA and indicate whether you would like to be enrolled in an HRA if you become or are ineligible to contribute to an HSA.

**HSA Established Date (Open or Boarding Date)**

The date that the bank account is established or opened. This is the date when you have completed the bank enrollment process and have a bank account number at Blue Healthcare Bank.

**Limited Expense Health Care Flexible Spending Account (LEX HCFSA)**

A benefit plan that is available to employees who are enrolled in a Federal Employee Health Benefits Program (FEHBP) HDHP with an HSA. Dental and vision care costs (for services/products that meet the IRS definition of medical care) are the only reimbursable expenses covered under the LEX HCFSA.

**Premium Pass Through**

We automatically pass through a portion of the total health Plan premium into your HSA or credit an equal amount to your HRA based upon your eligibility. The amount transferred is called the Premium Pass Through.

**Qualified Medical Expenses**

Those eligible expenses paid for care as described in Section 213(d) of the Internal Revenue Code. Additionally, the IRS has allowed over-the-counter drugs to qualify as eligible medical expenses. For more detailed information, refer to IRS Publication 502.

For the HRA, FEHB law does not permit Qualified Medical Expenses to include services, drugs, or supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.

Qualified Medical Expense substantiation refers to the process of determining that expenses submitted to an administrator (such as Blue Healthcare Bank) that are to be paid from HRAs, meet the requirements defined by IRS regulations.