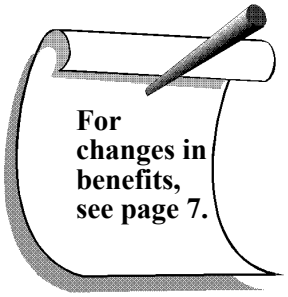
# Association Benefit Plan

# 2009

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




Who may enroll in this Plan: Civilian Active and Retired employees of the following organizations:

Office of DNI (ODNI) and Affiliated Centers
Central Intelligence Agency (CIA)
Defense Intelligence Agency (DIA)
Department of Defense (DOD)
Department of Energy, Office of Intelligence and Counterintelligence
Department of Homeland Security, Office of Intelligence and Analysis
Department of Treasury, Office of Intelligence and Analysis
Drug Enforcement Administration, Intelligence Division
Federal Bureau of Investigation
National Geospatial-Intelligence Agency (NGA)
National Reconnaissance Office (NRO)
National Security Agency (NSA)
Office of Naval Intelligence
State Department/INR
U.S. Air Force, Office of Intelligence and Air Intelligence Agency
U.S. Army, Office of Intelligence and Security Command
U.S. Coast Guard, Office of Intelligence and Criminal Investigations
U.S. Marine Corps, Office of Intelligence and Marine Intelligence Activity

Membership dues: There are no membership dues.

**Enrollment codes for this Plan:**
**421 – Self Only**
**422 – Self and Family**

Authorized for distribution by the:

**United States**
**Office of Personnel Management**

Center for
Retirement and Insurance Services
http://www.opm.gov/insure

**RI 72-007**

**Important Notice from Association Benefit Plan About**

**Our Prescription Drug Coverage and Medicare**

OPM has determined that the Association Benefit Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

**Please be advised**

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

**Medicare's Low Income Benefits**

*For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).*

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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# Introduction

This brochure describes the benefits of the Association Benefit Plan's contract (CS 1065) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is administered and underwritten by First Health Life and Health Insurance Company/Cambridge Life Insurance Company, which are Coventry Health Care Companies. The address for the Association Benefit Plan administrative office is:

Association Benefit Plan

PO Box 668587

Charlotte, NC 28266-8587

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on page 7. Rates are shown at the end of this brochure.

# Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

• Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means Association Benefit Plan.

• We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.

• Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

# Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

**Protect Yourself From Fraud** – Here are some things you can do to prevent fraud:

Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan or OPM representative.

• Let only the appropriate medical professionals review your medical record or recommend services.

• Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

• Carefully review explanations of benefits (EOBs) statements that you receive from us.

• Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

• If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 1-800-634-0069 and explain the situation.

If we do not resolve the issue:

**CALL – THE HEALTH CARE FRAUD HOTLINE**

**202-418-3300**

**OR WRITE TO:**

**United States Office of Personnel Management**

**Office of the Inspector General Fraud Hotline**

**1900 E. Street NW Room 6400**

**Washington, DC 20415-1100**

• Do not maintain as a family member on your policy:

Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

Your child over age 22 (unless he/she is disabled and is incapable of self support).

• If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.

• You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits, or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

## Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. **Ask questions if you have doubts or concerns.**

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. **Keep and bring a list of all the medicines you take.**

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. **Get the results of any test or procedure.**

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. **Talk to your doctor about which hospital is best for your health needs.**

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. **Make sure you understand what will happen if you need surgery.**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

  Exactly what will you be doing?

  About how long will it take?

  What will happen after surgery?

  How can I expect to feel during recovery?

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety:

- www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

# Section 1. Facts about this FFS plan

This Plan is a fee-for-service (FFS) Plan. You can choose your own physicians, hospitals, and other health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

**We have a Preferred Provider Organization (PPO) :**

Our fee-for-service plan offers services though a PPO. This means that certain hospitals and other health care providers are "preferred providers". When you reside in the PPO network area and use our PPO providers, you will receive covered services at reduced cost.

The Plan uses the Coventry Health Care National network as its PPO network in all states except New Jersey. In New Jersey the network is administered by QualCare.

To access the electronic directory visit www.CompassRoseBenefits.com. From left side of the home page, click Health Plan. From that page locate the grey box on the right side and click PPO Directory. Also, when you phone for an appointment, please verify that your physician is still a PPO provider. Contact us at 1-800-634-0069 for information concerning your PPO.

PPO benefits apply only when you reside in the PPO network area and use a PPO provider. **You must present your PPO identification (ID) card confirming your PPO participation to be eligible for PPO benefits.** Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply. If they are not they will be paid as non-PPO providers. When you use a PPO hospital, keep in mind that the health care professionals who provide services to you in the hospital, such as radiologists, emergency room physicians, anesthesiologists, and pathologists, may not be preferred providers in our PPO. We will provide the PPO benefit level for the non-PPO providers, however their respective charges will be subject to the Plan allowance as defined in Section 10.

If you reside in the PPO network area and no PPO provider is available, or if you do not use a PPO provider, non-PPO benefits apply.

If you reside outside the PPO network area, Out-of-network benefits apply.

**How we pay providers**

Our participating providers are generally reimbursed according to an agreed-upon fee schedule and are not offered additional financial incentives based on care provided or not provided to you. Our standard provider agreements do not contain any contractual provisions that include incentives to restrict a provider's ability to communicate with and advise patients of any appropriate treatment options. In addition, the Plan has no compensation, ownership, or other influential interests that are likely to affect provider advice or treatment decisions.

We may, through a negotiated agreement with some non-PPO health care providers, apply a discount to covered services that you receive from these providers.

To locate a non-PPO provider from whom a discount may be available, call the number on your identification card.

**Your rights**

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers, and facilities by calling 1-800-634-0069, or writing to Association Benefit Plan, PO Box 668587, Charlotte, NC 28266-8587.

**Your medical and claims records are confidential**

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

# Section 2. How we change for 2009

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

**Program-wide changes**

- In Section 3, under Covered providers, Illinois has been added to the list of medically underserved areas for 2009.

**Changes to this Plan**

- Your share of the premium will **decrease** for Self Only and For Self and Family. See back cover.
- We will change our PPO network to the Coventry National Network beginning January 1, 2009. See Section 1 for additional information.
- All Non-PPO services for surgical and anesthesia in Section 5 (b) are now subject to the annual deductible.
- The maximum dollar amount per visit for home health services had been increased to $120 per visit.
- The plan benefits for maternity physician services has been increased to 100% for PPO and Out-of-network providers. See page 24.
- The inpatient hospital per admission copay has been increased to $150 for PPO and $350 for Non-PPO.
- Chiropractic benefit has been added. See page 30.
- Coverage has been added for hearing aids up to $1,400 per aid per ear, once every five years.
- Hearing testing services are now covered at 100% for PPO, Non-PPO and Out-of-network with no deductible.
- A $50 per occurrence copay has been added for Accidental and Medical Emergencies. See page 43.
- Benefits have been added for augmentative and alternative communication devices at 100% up to $1,000 per year for PPO, Non-PPO and Out-of-Network. See page 29.
- The Plan has added coverage for new transplant surgeries. See page 35.
- The Non-Medicare Network Retail Tier 2 copay has been increased to $30.
- The Non-Medicare Mail Order Tier 2 copay has been increased to $60.
- The Medicare Mail Order Tier 2 copay has been increased to $36.

# Section 3. How you get care

**Identification cards**

We will send you an identification (ID) card. You should carry this card with you at all times. You must show your ID card whenever you receive services from a medical or dental provider, and to fill a prescription at a participating Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF2809 or your health benefits enrollment confirmation (for annuitants).

If you do not receive your card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-634-0069.

**Where you get covered care**

You can get care from any "covered provider" or "covered facility." How much we pay—and you pay—depends on the type of covered provider or facility you use. If you reside in the PPO network area and use our preferred providers, you will pay less.

- **Covered Providers**

We consider the following to be covered providers when they perform services within the scope of their license or certification:

**Physician**:Doctors of medicine or psychiatry (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), chiropractic (D.C.),and optometry (O.D.) when acting within the scope of their licenses or certification.

**Qualified Clinical Psychologist**:An individual who has earned either a Doctoral or Masters Clinical Degree in psychology or an allied discipline and who is licensed or certified in the state where services are performed. This presumes a licensed individual has demonstrated to the satisfaction of state licensing officials that he/she, by virtue of academic and clinical experience, is qualified to provide psychological services in that state.

**Nurse Midwife:** A person who is certified by the American College of Nurse Midwives or is licensed or certified as a nurse midwife in states requiring licensure or certification.

**Nurse Practitioner/Clinical Specialist:** A person who 1) has an active R.N. license in the United States, 2) has a baccalaureate or higher degree in nursing, and 3) is licensed or certified as a nurse practitioner or clinical nurse specialist in states requiring licensure or certification.

**Clinical Social Worker:** A social worker that 1) has a Master's or Doctoral degree in social work, 2) has at least two years of clinical social work practice, and 3) in states requiring licensure, certification or registration, is licensed, certified, or registered as a social worker where the services are rendered.

**Speech, Occupational and Physical Therapists**: A professional who is licensed or meets state requirements where the services are performed to provide Speech, Occupational or Physical therapy services.

**Physician Assistant:** A person who is licensed, registered, or certified in the state where services are performed.

**Licensed Professional Counselor or Master's Level Counselor:** A person who is licensed, registered, or certified in the state where services are performed.

**Audiologist:** A person who is licensed, registered, or certified in the state where services are performed.

**Licensed Acupuncturist (L.A.C.):** A person who has completed the required schooling and licensure to perform acupuncture in the state where services are performed (see definition of acupuncture benefits, Section 5(a)).

**Christian Science Practitioner:** If you choose to visit a Christian Science practitioner instead of a physician, the charges are still considered allowable expenses. To qualify for benefits, you must make this choice annually. The benefits will then apply to all subsequent expenses incurred during the year. You can change your mind only at the time of your first claim each year. The practitioner you choose must be listed as such in the *Christian Science Journal* that is current at the time the service is provided. Your choice will not apply to, or prevent payment of, a physician's maternity charges.

**Medically underserved areas.** Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in the states OPM determines are "medically underserved". For 2009, the states are: Alabama, Arizona, Idaho, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, and Wyoming.

- **Covered facilities**

Covered facilities include:

**Hospital:**

1) An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or

2) Any other institution that is operated pursuant to law, under the supervision of a staff of doctors and with 24-hour-a-day nursing service, and that is primarily engaged in providing:

a) General patient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control; or

b) specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.

3) For inpatient and outpatient treatment of mental health and substance abuse, the term hospital also includes a freestanding residential treatment center facility approved by the JCAHO.

In no event shall the term hospital include a convalescent nursing home or institution or part thereof that:

- is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged;
- furnishes primarily domiciliary or custodial care including training in the routines of daily living;
- or is operated as a school.

**Nursing School Administered Clinic:** A clinic that is

- licensed or certified in the state where the services are performed, and
- provides ambulatory care in an outpatient setting—primarily in rural or inner city areas where there is a shortage of physicians. Services billed for by these clinics are considered outpatient 'office' services rather than facility charges.

**Skilled nursing facility:** An institution, or that part of an institution that provides convalescent skilled nursing care 24 hours a day and is classified as a skilled nursing facility under Medicare.

**Birthing Center**: A licensed facility that is equipped and operated solely to provide care, to perform uncomplicated spontaneous deliveries and to provide immediate postpartum care.

**Hospice**: A facility that meets all of the following:

1) primarily provides inpatient hospice care to terminally ill persons;

2) is certified by Medicare as such, or is licensed or accredited as such by the jurisdiction it is in;

3) is supervised by a staff of M.D.'s or D.O.'s, at least one of whom must be on call at all times;

4) provides 24-hour-a-day nursing services under the direction of an R.N. and has a full-time administrator; and

5) provides an ongoing quality assurance program.

**What you must do to get covered care**

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

- **Transitional care**

**Specialty care:** If you have a chronic or disabling condition and

• lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan, or

• lose access to your PPO specialist because we terminate our contract with your specialist for reasons other than cause,

you may be able to continue seeing your specialist and receiving any PPO benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and your PPO benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-634-0069. If you are new to the FEHB Program, we will reimburse you for your covered expenses while you are in the hospital beginning of the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

• You are discharged, not merely moved to an alternative care center; or

• The day your benefits from your former plan run out; or

• The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

**How to get approval for**

- **Your hospital stay**

**Precertification** is the process by which —prior to your hospital admission or residential treatment care—we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. Unless we are misled by the information given to us, we will not change our decision on medical necessity.

In most cases, your physician or hospital will take care of precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital if they have contacted us.

- **Warning**:

We will reduce our benefits for the inpatient hospital stay or residential treatment care by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will not pay any benefits.

- **How to precertify an admission**

• You, your representative, your doctor, or your hospital must call us at 1-888-234-4103 before admission.

• If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

• Provide the following information:

- Enrollee's name and Plan identification number;
- Patient's name, birth date, and phone number;
- Reason for hospitalization, proposed treatment, or surgery;
- Name and phone number of admitting doctor;
- Name of hospital or facility; and
- Number of planned days of confinement.

We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

- **Maternity care**

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

- **If your hospital stay needs to be extended**

If your hospital stay—including for maternity care—needs to be extended, you, your representative, your physician or the hospital must ask us to approve the additional days.

**What happens when you do not follow the precertification rules**

• If no one contacted us, we will decide whether the hospital stay was medically necessary.

• If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty.

If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

If no one contacted us for specified services such as Hospice Care, Skilled Nursing Facility Care, Home Health Care, we will disqualify higher paid benefits.

When we precertified the admission but you remained in the hospital beyond the number of days we approved and did not get the additional days precertified, then:

• for the part of the admission that was medically necessary, we will pay inpatient benefits, but

for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

**Exceptions**

You do not need precertification in these cases:

• You are admitted to a hospital outside the United States.

• You have another group health insurance policy that is the primary payer for the hospital stay.

• Medicare Part A is the primary payer for the hospital stay. Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payer and you do need precertification.

**Other services**

Some other services require precertification or prior authorization, such as:

• Home health care (See Section 5(a))

• Hospice care (See Section 5(c))

• Skilled nursing facilities (See Section 5(c))

• Mental health and substance abuse treatment (See Section 5(e))

• Some prescription drugs (See Section 5(f))

• Organ/tissue transplants (See Section 5(b))

# Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care.

**Cost-sharing**

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

**Copayments**

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. You will only be responsible for one copayment per day per provider.

Example: When you see your PPO physician you pay a copayment of $10 per day, and when you go in a PPO hospital, you pay a copayment of $150 per hospital stay.

Note: If the billed amount or the Plan allowance that providers we contract with have agree to accept as payment in full is less than your copayment, you pay the lower amount.

**Deductible**

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible.

• The calendar year deductible is $300 per person. Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $600.

If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your deductible, you must pay $80. We will apply $80 to you deductible. We will begin paying benefits once the remaining portion of your calendar year deductible $300 has been satisfied.

Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

**Coinsurance**

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: You pay 10% coinsurance of our allowance for an X-ray at a PPO provider.

**If your provider routinely waives your cost**

Note: If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

For example, if your physician ordinarily charges $100 for a service but routinely waives your 10% coinsurance, the actual charge is $90. We will pay $81 (90% of the actual charge of $90).

**Waivers**

In some instances, a provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 1-800-634-0069.

**Differences between our allowance and the bill**

Our “Plan allowance” is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For more information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

When you live in the Plan’s PPO area, you should use a PPO provider. The following two examples explain how we will handle your bill when you go to a PPO provider and when you go to a non-PPO provider. When you use a PPO provider, the amount you pay is much less.

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a PPO physician who charges $350, but our allowance is $300. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just 10% of our $300 allowance ($30). Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and his bill.

Follow these procedures when you use a PPO provider in order to receive PPO benefits:

- Verify with us that your address of record is in a PPO area;
- When you phone for an appointment, verify that the physician or facility is still a PPO provider and;
- Present your PPO ID card confirming your PPO participation in order to receive PPO benefits.

• **Non-PPO providers,** on the other hand, have no agreement to limit what they will bill you. For instance,

- **When you reside in the PPO network area and use a non-PPO provider**, you will pay your deductible and coinsurance—plus any difference between our allowance and charges on the bill. Here is an example: You see a non-PPO physician who charges $350 and our allowance is again $300. Because you've met your deductible, you are responsible for your coinsurance, so you pay 30% of our $300 allowance ($90). Plus, because there is no agreement between the non-PPO physician and us, the physician can bill you for the $50 difference between our allowance and his/her bill.
- **When you reside outside the PPO network area,** you will pay your deductible and coinsurance – plus any difference between our allowance and charges on the bill. As in the example above, once you have met your deductible, you are responsible for your coinsurance. You will pay 15% of our allowance ($45) and the physician can bill you for the $50 difference between our allowance and his/her bill.

The following table illustrates the examples of how much you have to pay out-of-pocket for services from a PPO physician vs. a non-PPO physician when you reside in the PPO network area. The table uses our example of a service for which the physician charges $350 and our allowance is $300. The table shows the amount you pay if you have met your calendar year deductible.

| **EXAMPLE** | **PPO physician** | **Non-PPO physician** |
|---|---|---|
| Physician's charge | $350 | $350 |
| Our allowance | We set it at: $300 | We set it at: $300 |
| We pay | 90% of our allowance: $270 | 70% of our allowance: $210 |
| You owe: Coinsurance | 10% of our allowance: $30 | 30% of our allowance: $90 |
| +Difference up to charge? | No: 0 | Yes: $50 |
| **TOTAL YOU PAY** | **$30** | **$140** |

**Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments**

For those benefits where coinsurance or deductibles apply, we pay 100% of the Plan allowance for the rest of the calendar year after your expenses total:

• PPO providers: $3,500—For you or any covered family member;

• Non-PPO providers: $7,000—For you or any covered family member;

• Out-of-network providers: $3,000—For you or any covered family member.

Out-of-pocket expenses are:

• Your $300/$600 calendar year deductible;

• The percentage you pay for covered services after you have met your deductibles;

• The percentage you pay for surgery, anesthesia and extended medical care after an accidental injury; and

• Your copayment for hospital stays.

The following cannot be included in your out-of-pocket expenses:

- Expenses in excess of the Plan allowance or maximum benefit limitations;
- Non-covered services and supplies;
- Prescription drug copayments;
- Copayments, except for hospital admission copayments;
- Expenses for dental care including the 20% you pay for dental care after an accidental injury; or
- Any amounts you pay if benefits have been reduced because of noncompliance with our precertification, prior authorization or prior approval requirements.

| | |
|---|---|
| **Carryover** | If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.<br><br>Note: If you change options in the Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option. |
| **If we overpay you** | We will make diligent efforts to recover benefit payments we made in error, but in good faith. We may reduce subsequent benefit payments to offset overpayments. |
| **When Government facilities bill** | Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. |

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

Under the FEHB law, we must limit our payments for inpatient hospital care and physician care to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital care and non-physician based care are not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

**If you....**

- are age 65 or over, and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, or as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

**Then, for your inpatient hospital care,**

- the law requires us to base our payment on an amount—the "equivalent Medicare amount"—set by Medicare's rules for what Medicare would pay, not on the actual charge;
- you are responsible for your applicable deductibles, coinsurance, or copayments you owe under this Plan;
- you are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits; and
- the law prohibits a hospital from collecting more than the equivalent Medicare amount.

**And, for your physician care,** the law requires us to base our payment and your coinsurance or copayment on…

- an amount set by Medicare and called the "Medicare approved amount," or
- the actual charge if it is lower than the Medicare approved amount.

| If your physician… | Then you are responsible for… |
|---|---|
| Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network, | your deductibles, coinsurance, copayments; |
| Participates with Medicare and is **not** in our PPO network, | your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount; |
| Does not participate with Medicare, | your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount. |

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

**When you have the Original Medicare Plan (Part A, Part B, or both)**

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare A (Hospital insurance) and Medicare B (Medical insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the statement is submitted to determine our payment for covered services provided to you if Medicare does not pay the VA facility.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

If your physician accepts Medicare assignment, then you pay nothing for covered charges.

If your physician does not accept Medicare assignment, then you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment.

It's important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) that Medicare will send you will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Please see Section 9, *Coordinating Benefits With Other Coverage*, for more information about how we coordinate benefits with Medicare.

# Section 5. Benefits High Option

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# High Option Overview

This Plan offers a single benefit, with a three tier reimbursement structure. Please refer to specific benefits sections of the brochure for information regarding reimbursement. Make sure that you review the benefits that are available under the Plan.

Highlights of this plan include, but are not limited to:

- $10 co-payment for physician's office visits
- The maximum benefits for annual physical exams is $700 per calendar year
- Benefits for HPV, Rotovirus and Adacel have been included for preventive care for adults and children
- Alternative benefit provided for Chiropractor
- Plan provides 100% coverage for maternity for PPO network and Out-of-network.

To obtain claim forms, claims filling advice, or more information about the Plan, contact us at 1-800-634-0069 at our Web site at www.CompassRoseBenefits.com

See page 7 for how our benefits changed this year. Make sure that you review the benefits that are available.

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

**Important things you should keep in mind about these benefits:**

• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

• The calendar year deductible is: $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No Deductible)" to show when the calendar year deductible **does not** apply.

• PPO benefits apply only when you reside in the PPO network area and use a PPO provider. When no PPO provider is available, non-PPO benefits apply. Out-of-network benefits apply when you reside outside the PPO network area.

• Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

| Benefit Description | You Pay |
|---|---|
| **Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.** | |
| **Diagnostic and treatment services** | |
| Professional services of physicians (not including surgery)<br>• In physician's office<br>- office visits<br>- consultations (to include second surgical opinion)<br>- injections<br>Note: Drugs provided by the physician are covered under Section 5(f).<br>Note: Supplies provided by the physician are covered under Section 5(a). | PPO: $10 copayment (No Deductible)<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount<br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount |
| Professional services of physicians (not including surgery)<br>• In a hospital (Inpatient or Outpatient)<br>• In an urgent care center<br>• In a skilled nursing facility<br>• At home | PPO: 10% of the Plan allowance<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount<br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount |
| **Lab, X-ray and other diagnostic tests** | |
| Tests, such as:<br>• Blood tests<br>• Urinalysis<br>• Non-routine pap tests<br>• Pathology<br>• X-rays<br>• Non-routine mammograms<br>• CAT Scans/MRI | PPO: 10% of the Plan allowance<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount<br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount. |

*Lab, X-ray and other diagnostic tests - continued on next page*

| Benefit Description | You Pay |
|---|---|
| **Lab, X-ray and other diagnostic tests (cont.)** | |
| • Ultrasound<br>• Electrocardiogram and EEG<br>• Sonograms | PPO: 10% of the Plan allowance<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount.<br><br>Nothing if Lab Card is used for Laboratory Services (No deductible)<br><br>Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges. |
| **Preventive care, adult** | |
| Routine physical examination per person to include a history and physical, chest X-ray, urinalysis, blood tests, and EKG (electrocardiogram). Up to a maximum of $700 per calendar year. | PPO: **Services in physician's offic**e Nothing up to the $700 maximum and all charges in excess of the $700 maximum (No Deductible)<br><br>PPO: **Services outside physician's office** Nothing up to the $700 maximum and all charges in excess of the $700 maximum (No Deductible)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the $700 maximum (No Deductible)<br><br>Out-of-Network: 15% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the $700 maximum (No Deductible) |
| The following are paid in addition to the above $700 benefit:<br>• One annual cervical cancer screening (Pap smear) for women age 18 and older. Note: if you see another physician for your pap smear, the office visit will be covered under Section 5(a)-Diagnostic and treatment services.<br>• One annual Prostate Specific Antigen (PSA) test (prostate cancer screening) for men age 40 and older.<br>• One annual fecal occult blood test (colorectal cancer screening) for members age 40 and older.<br>• One routine sigmoidoscopy every five years starting at age 50.<br>• One routine colonoscopy every ten years starting at age 50.<br>• One annual routine mammogram (breast cancer screening) for women age 35 and older.<br>• One annual fasting and one non-fasting blood cholesterol test every three consecutive calendar years<br>• Chlamydial screening | PPO: 10% of Plan allowance (No Deductible)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible)<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |

*Preventive care, adult - continued on next page*

| Benefit Description | You Pay |
|---|---|
| **Preventive care, adult (cont.)** | |
| • One-time ultrasonography for abdominal aortic aneurysm screening, for males between the ages of 65 to 75 who have ever smoked.<br>• Annual osteoporosis routine screening for members age 60 and older<br><br>Note: Your physician's bill **must** clearly state "Routine Physical Exam." If a medical diagnosis is provided on the bill, those services will be paid under the medical benefit.<br><br>Note: We cover related services under the applicable benefits section (i.e. for facility charge, see Section 5(c)). | PPO: 10% of Plan allowance (No Deductible)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible)<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |
| Adult routine immunizations endorsed by the Centers of Disease Control and Prevention (CDC) :<br>• Tetanus-diphtheria (Td) booster once every 10 years, ages 22 and over<br>• Pneumococcal vaccine, annually<br>• Influenza vaccine, annually<br>• Varicella (Chickenpox) age 22 and older<br>• Shingles Vaccine, age 60 and older<br>• HPV, Adacel and Rotavirus Vaccines | PPO: 10% of Plan allowance (No deductible)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible)<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |
| **Preventive care, children** | |
| • Childhood immunizations recommended by the American Academy of Pediatrics (to age 22)<br>• Rotavirus vaccine for infants less than 1 year old<br>• HPV, Adacel Vaccine and Rotavirus<br>• Retinal Screening Exam performed by an ophthalmologist for infants with low birth weight less than 1 year of age and with an unstable clinical course.<br>• Routine screening, testing, diagnosis and treatment (including hearing aids) for hearing loss. | PPO: Nothing (No Deductible)<br><br>Non-PPO: Only the difference between the Plan allowance and the billed amount (No Deductible)<br><br>Out-of-network: Only the difference between the Plan allowance and the billed amount (No Deductible) |
| • Well-child care charges for routine examinations and care (to age 2):<br><br>• One annual routine physical examination (over age 2 to age 22): | PPO: $10 copayment (No Deductible)<br><br>PPO: Services outside physician's office Nothing (No Deductible)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount. (No Deductible) |

| Benefit Description | You Pay |
|---|---|
| **Maternity care** | |
| Complete maternity (obstetrical) care such as:<br>• Prenatal care (to include laboratory tests)<br>• Amniocentesis<br>• Delivery<br>• Initial, routine examination of your newborn infant covered under your family enrollment<br>• Postnatal care<br>• One routine sonogram<br>**Note: Here are some things to keep in mind**<br>• You do not have to precertify your normal delivery; see page 11 for other circumstances, such as extended stays for you or your baby.<br>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary.<br>• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. If your baby stays in the hospital after your discharge and is covered under your Self and Family enrollment, you must pay a separate hospital stay copayment. See Section 5(c).<br>• Surgical benefits, not maternity benefits, apply to circumcision.<br>• Bassinet or nursery charges on which you and your baby are confined are considered your maternity expenses, not your baby's.<br>• Sonograms and other related tests that are not included in your routine prenatal or postnatal care are covered in Lab, X-ray, and other diagnostic tests, see page 22. | PPO: Nothing (No Deductible)<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible)<br>Out-of-network: Nothing (No Deductible) |
| *Not covered:*<br>*Routine sonograms to determine fetal age, size or sex; or 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.* | *All charges* |

| Benefit Description | You Pay |
|---|---|
| **Family Planning** | |
| A range of voluntary family planning services, limited to:<br>• Voluntary sterilization (See Section 5(b) for surgical procedures)<br>• Surgically implanted contraceptives (See Section 5(b) for surgical procedures)<br>• Fitting, inserting or removing intrauterine devices (such as diaphragms and IUDs)<br>*Note: We cover FDA-approved prescription drugs and devices for birth control in Section 5(f).* | PPO: 10% of the Plan allowance (No Deductible)<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount<br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |
| Injection of contraceptive drugs (such as Depo-Provera) | PPO: $10 copay (No Deductible) |
| *Not covered:*<br>• *Reversal of voluntary surgical sterilization, genetic counseling.* | *All Charges* |
| **Infertility services** | |
| Diagnosis and treatment of infertility except as shown in *Not covered.*<br>• Initial diagnostic tests and procedures done only to identify the cause of infertility<br>• Fertility drugs, hormone therapy and related services<br>• Medical or surgical procedures done to create or enhance fertility<br>Note: We will pay up to $5,000 per person per lifetime for covered infertility services, including prescription drugs. | PPO: 10% of the Plan allowance and charges in excess of the $5,000 maximum<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and charges in excess of the $5,000 maximum<br>Out of network: 15% of the Plan allowance and any difference between our allowance and the billed amount and charges in excess of the $5,000 maximum |
| *Not covered:*<br>• *Infertility services after voluntary sterilization*<br>• *Assisted reproductive technology (ART) procedures, such as:*<br>• *artificial insemination*<br>• *invitro fertilization*<br>• *embryo transfer and gamete intrafallopian transfer (GIFT)*<br>• *intravaginal insemination (IVI)*<br>• *intracervical insemination (ICI)*<br>• *intrauterine insemination (IUI)*<br>• *Services and supplies related to ART procedures*<br>• *Cost of donor sperm* | *All Charges* |

*Infertility services - continued on next page*

| Benefit Description | You Pay |
|---|---|
| **Infertility services (cont.)** | |
| • *Cost of donor egg* | *All Charges* |
| **Allergy care** | |
| Allergy testing, injections and treatment (including allergy serum). | PPO services **in physician's office:** $10 copayment (No Deductible)<br><br>PPO services **outside physician's office:** 10% of the Plan allowance<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount<br><br>Out of network: 15% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *RAST tests*<br>• *Food tests*<br>• *End Point titration techniques*<br>• *Sublingual allergy desensitation*<br>• *Hair analysis* | *All charges* |
| **Treatment therapies** | |
| • Chemotherapy and radiation therapy (High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b), Organ/tissue transplants.)<br><br>• Renal Dialysis<br><br>• Intravenous (IV)/Infusion Therapy Home IV and antibiotic therapy<br><br>• Respiratory and inhalation therapies<br><br>• Growth hormone therapy (GHT) (We only cover GHT when you obtain prior approval. Call 1-800-634-0069 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies). See Other Services under How to get approval for...in Section 3.Note: We cover drugs administered for the therapies listed above in Section 5(f). | PPO: 10% of the Plan allowance<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount |

| Benefit Description | You Pay |
|---|---|
| **Physical, occcupational, and speech therapies** | |
| 90 Total combined outpatient physical, speech and occupational therapy visits per calendar year for the following:<br><br>Visits for the services of each of the following:<br>• physicians<br>• qualified physical therapists;<br>• speech therapists; and<br>• occupational therapists<br><br>Note: 90 total combined visits does not include inpatient physical, speech and occupational therapy which is covered under Section 5 (c) hospital or facility coverage.<br><br>**Note: Therapy may not be rendered by a chiropractor.** | PPO: 10% of the Plan Allowance<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount. |
| Note: We only cover therapy when a physician:<br>• orders the care;<br>• identifies the specific professional skills you require and the medical necessity for skilled services; and<br>• indicates the length of time you need the services.<br><br>Note: We only cover physical and occupational therapy to restore bodily function when there has been a total or partial loss due to illness or injury.<br><br>Note: Inpatient rehabilitative services are covered under Section5 (c) | |
| Not covered:<br>• *Long-term rehabilitative therapy*<br>• *Exercise programs* | *All Charges* |
| **Hearing services (testing, treatment, and supplies)** | |
| Hearing aids for adults - one hearing aid and related services per ear every five calendar years. | PPO, Non-PPO and Out-of-network: All charges over $1,400 for one hearing aid per ear. |
| *Note: Hearing exams other than routine or initial exam, when medically necessary, are covered under Medical Services and Supplies, Section 5(a).* | |
| **Vision services (testing, treatment, and supplies)** | |
| One pair of eyeglasses or contact lenses per incident to correct an impairment directly caused by:<br><br>• Accidental ocular injury or<br><br>• Surgery in connection with the following diagnosis specifically ordered by the physician:<br>• Cataract<br>• Keratoconus or<br>• Glaucoma | PPO: 10% of the Plan allowance<br><br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount |

*Vision services (testing, treatment, and supplies) - continued on next page*

| Benefit Description | You Pay |
|---|---|
| **Vision services (testing, treatment, and supplies) (cont.)** | |
| Note: Services must be received within one year of the date of accident or surgery. | PPO: 10% of the Plan allowance<br><br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount |
| Not covered:<br>• Eyeglasses or contact lenses and examinations for them, except for accidental injury and intraocular surgery.<br>• Eye exercises and orthoptics<br>• *Radial keratotomy and other refractive surgery*<br>• *Eye refractions* | *All Charges* |
| **Foot care** | |
| We do not provide benefits for routine foot care, such as:<br>• Treatment or removal of corns and calluses, or trimming of toenails<br>• Orthopedic shoes, orthotics and other supportive devices for the feet | *All Charges* |
| **Orthopedic and prosthetic devices** | |
| • Orthopedic braces<br><br>• Artificial limbs and eyes to replace natural limbs and eyes; stump hose<br><br>• Externally worn breast prostheses and surgical bras including necessary replacements following a mastectomy<br><br>• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy.<br><br>Note: See Section 5(b) for coverage of the surgery to insert the device and Section 5(c) for hospital or facility coverage. | PPO: 10% of the Plan allowance<br><br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount |
| Wigs up to a $300 maximum while covered under this Plan, when required due to hair loss in connection with chemotherapy or radiation treatment | Nothing up to the lifetime maximum of $300 (No Deductible). All charges over the $300 lifetime maximum. |
| *Not covered:*<br>• *Arch supports*<br>• *Foot orthotics*<br>• *Heel pads and heel cups*<br>• *Corsets, trusses, elastic stockings, support hose, and other supportive devices* | *All Charges* |

*Orthopedic and prosthetic devices - continued on next page*

| Benefit Description | You Pay |
|---|---|
| **Orthopedic and prosthetic devices (cont.)** | |
| • *Lumbosacral supports* | *All Charges* |
| **Durable medical equipment (DME)** | |
| Durable medical equipment (DME) is equipment and supplies that:<br>1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury);<br>2. Are medically necessary;<br>3. Are primarily and customarily used only for a medical purpose;<br>4. Are generally useful only to a person with an illness or injury;<br>5. Are designed for prolonged use; and<br>6. Serve a specific therapeutic purpose in the treatment of an illness or injury.<br><br>We cover purchase or rental up to the purchase price, at our option, including repair and adjustment, of durable medical equipment. Under this benefit, we also cover:<br>• Oxygen;<br>• Hospital beds;<br>• Dialysis equipment;<br>• Respirators;<br>• Wheelchairs, crutches, canes, walkers, casts;<br>• Cervical collars and traction kits; and<br>• Splints | PPO: 10% of the Plan allowance<br><br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount |
| We cover rental or purchase of augmentative and alternative communication devices such as:<br>• Computer story boards<br>• Light talkers<br>• Enhanced vision systems<br>• Speech aid prosthesis for pediatrics<br>• Speech aid prosthesis for adults | PPO, Non-PPO and Out-of-network:<br><br>Nothing up to the $1,000 annual maximum benefit, then all charges. |
| Not covered:<br><br>*Sun or heat lamps, whirlpool baths, heating pads, air purifiers, humidifiers, air conditioners, and exercise devices* | *All Charges* |

| Benefit Description | You Pay |
|---|---|
| **Home health services** | |
| For services provided on a **part-time basis** (less than an 8-hour shift):<br><br>If **precertified**, 90 visits per calendar year up to a maximum Plan payment of $120 per visit when:<br>• A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services;<br>• The attending physician orders the care;<br>• The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and<br>• The physician indicates the length of time the services are needed.<br><br>If **not precertified**, 40 visits per calendar year up to a maximum plan payment of $40, subject to the above provisions<br><br>NOTE: Precertified and Nonprecertified visits are combined. Visit limit not to exceed 90 visits per calendar year.<br><br>NOTE: All therapy services will count toward the 90-day therapy visit limitation per calendar year, as listed under Physical, occupation and speech therapy in Section 5(a). | PPO: Charges in excess of $120 per visit (No Deductible) (90 visit maximum). All charges over the visit limit.<br><br>Non-PPO: Charges in excess of $120 per visit and any difference between the Plan allowance and the billed amount (No Deductible) (90 visit maximum). All charges over the visit limit.<br><br>Out-of-network: Charges in excess of $120 per visit and any difference between the Plan allowance and the billed amount (No Deductible) (90 visit maximum). All charges over the visit limit.<br><br>**If not precertified**, 40 visits per calendar year up to a maximum plan payment of $40, subject to the above provisions. |
| For private duty nursing provided on a **full-time basis** (more than an 8-hour shift) by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) when:<br>• the care is ordered by the attending physician, and<br>• your physician identifies the specific professional nursing skills that you require, as well as the length of time needed. | PPO: 10% of the Plan allowance<br><br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount |
| *Not covered:*<br>• *Nursing care requested by, or for the convenience of, the patient or the patient's family;*<br>• *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, rehabilitative:*<br>• *Custodial care as defined in Section 10.* | *All Charges* |
| **Chiropractic** | |
| Covered services are limited to:<br>• Manipulation of the spine and extremities<br><br>Note: Chiropractic is a system of therapy that attributes disease to abnormal function of the nervous system and attempts to restore normal function by manipulation of the spinal column and other body structures. | PPO: Nothing (No Deductible) up to $20 per visit and up to the Plan maximum of 20 visits per person per calendar year.<br><br>Non-PPO: All Charges<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount. Maximum of 20 visits per person per calendar year. |

| Benefit Description | You Pay |
|---|---|
| **Alternative treatments** | |
| Acupuncture when used as an anesthetic agent for covered surgery | PPO: 10% of the Plan allowance (No Deductible)<br><br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible)<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |
| *Not covered:*<br>• *Chelation therapy except for acute arsenic, gold, mercury, lead, or use of Deferoxamine in iron poisoning*<br>• *Naturopathic services*<br>• *Homeopathic services and medicines*<br><br>*(Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas)* | *All Charges* |
| **Educational classes and programs** | |
| Coverage is limited to:<br><br>• Smoking Cessation Up to $100 maximum per person per calendar year to include Individual/Group counseling and over-the-counter (OTC) drugs | PPO: 10% of the Plan allowance and all charges in excess of the $100 maximum (No Deductible)<br><br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the $100 maximum (No Deductible)<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount and all charges in excess of the $100 maximum (No Deductible) |
| Office visits for Smoking Cessation<br><br>Diabetes training<br><br>Note: Prescription drugs are covered under Section 5(f). | PPO: $10 copayment (No Deductible)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible)<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |

## Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

**Important things you should keep in mind about these benefits:**

• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

• The calendar year deductible does not apply for these benefits; however, we added —"(No Deductible)" - to show that the calendar year deductible does not apply.

• PPO benefits apply only when you reside in the PPO network area and use a PPO provider. When no PPO provider is available, non-PPO benefits apply. Out-of-network benefits apply when you reside outside the PPO network area.

• Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

• The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).

**YOU MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification.**

| Benefit Description | You Pay<br>After the calendar year deductible… |
|---|---|
| **Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".** | |
| **Surgical procedures** | |
| A comprehensive range of services, such as:<br>• Operative procedures<br>• Treatment of fractures, including casting<br>• Normal pre- and post-operative care by the surgeon<br>• Correction of amblyopia and strabismus<br>• Endoscopy procedures<br>• Biopsy procedures<br>• Electroconvulsive therapy<br>• Removal of tumors and cysts<br>• Correction of congenital anomalies (see Reconstructive surgery ) | PPO: 10% of the Plan allowance (No deductible)<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)<br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) |
| • Surgical treatment of morbid obesity (bariatric surgery) – a condition in which an individual (1) is the greater of 100 pounds or 100% over his/her normal weight (in accordance with our underwriting standards) with complicating conditions; (2) has been so for at least five years with documented unsuccessful attempts to reduce under a doctor-monitored diet and exercise program and (3) is age 18 or older.<br>• Insertion of internal prosthetic devices. See Section 5(a) for device coverage information.<br>• Voluntary sterilization (e.g., tubal ligation, vasectomy) | PPO: 10% of the Plan allowance (No Deductible)<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)<br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |

*Surgical procedures - continued on next page*

| Benefit Description | You Pay<br>After the calendar year deductible… |
|---|---|
| **Surgical procedures (cont.)** | |
| • Surgically implanted contraceptives, and intrauterine devices (IUDs)<br>• Treatment of burns<br>• Surgical treatment of bunions or spurs<br>• Assistant surgeons - we cover up to 20% of our allowance for the surgeon's charge<br>Note: For related services, see applicable benefits section (i.e., for inpatient hospital benefits, see Section 5(c)). | PPO: 10% of the Plan allowance (No Deductible)<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)<br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |
| When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are:<br>• For the primary procedure:<br>• PPO: 90% of the Plan allowance (No Deductible)<br>• Non-PPO: 70% of the Plan allowance (calendar year deductible applies)<br>• Out-of-network: 85% of the Plan allowance (No Deductible)<br>• For the secondary procedure(s):<br>• PPO: 90% of one-half of the Plan allowance (No Deductible)<br>• Non-PPO: 70% of one-half of the Plan allowance (calendar year deductible applies)<br>• Out-of-network: 85% of one-half of the Plan allowance (No Deductible)<br>Note: Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures. | PPO: 10% of the Plan allowance for the primary procedure and 10% of one-half of the Plan allowance for the secondary procedure(s) (No Deductible)<br>Non-PPO: 30% of the Plan allowance for the primary procedure and 30% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount (calendar year deductible applies)<br>Out-of-network: 15% of the Plan allowance for the primary procedure and 15% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount (No Deductible)<br>Note: For certain surgical procedures, we may apply a value of less than 50% of subsequent procedures. |
| Not covered:<br>*Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary* | *All Charges.* |
| **Reconstructive surgery** | |
| Surgery to correct a functional defect<br>Surgery to correct a condition caused by injury or illness if:<br>• the condition produced a major effect on the member's appearance and<br>• the condition can reasonably be expected to be corrected by such surgery | PPO: 10% of the Plan allowance (No Deductible)<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)<br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |

*Reconstructive surgery - continued on next page*

| Benefit Description | You Pay<br>After the calendar year deductible… |
|---|---|
| **Reconstructive surgery (cont.)** | |
| Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of the congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. | PPO: 10% of the Plan allowance (No Deductible)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |
| All stages of breast reconstruction surgery following a mastectomy, such as:<br>• surgery to produce a symmetrical appearance of breasts;<br>• treatment of any physical complications, such as lymphedemas;<br>• breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage)Note: Internal breast prostheses are covered under Section 5(a).<br><br>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. | PPO: 10% of the Plan allowance (No Deductible)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed (calendar year deductible applies)<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |
| Not covered:<br>• *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*<br>• *Surgeries related to sex transformation or sexual dysfunction* | *All Charges.* |
| **Oral and maxillofacial surgery** | |
| Oral surgical procedures, limited to:<br>• Reduction of fractures of the jaws or facial bones<br>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion<br>• Removal of stones from salivary ducts<br>• Excision of leukoplakia or malignancies<br>• Excision of cysts and incision of abscesses when done as independent procedures<br>• Surgical correction of temporomandibular joint (TMJ) dysfunction<br>• Surgical removal of impacted teeth, including anesthesia charges<br>• Other surgical procedures that do not involve the teeth or their supporting structures | PPO: 10% of the Plan allowance (No Deductible)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |

*Oral and maxillofacial surgery - continued on next page*

| Benefit Description | You Pay<br>After the calendar year deductible… |
|---|---|
| **Oral and maxillofacial surgery (cont.)** | |
| *Not covered:*<br>• *Oral implants, transplants and related services*<br>• *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*<br>• *Pre- and post-operative examinations in preparation for surgical removal of impacted teeth* | *All Charges.* |
| **Organ/tissue transplants** | |
| Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to Other services in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description.<br><br>Solid organ transplants are limited to:<br>• Cornea<br>• Heart<br>• Heart/Lung<br>• Single, double or lobar lung<br>• Kidney<br>• Liver<br>• Pancreas<br>• Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis<br>• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach and pancreas<br><br>Blood or marrow stem cell transplants limited to the stages of the following diagnoses:<br><br>Allogeneic transplants for:<br>• Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia<br>• Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)<br>• Advanced Hodgkin's lymphoma<br>• Advanced non-Hodgkin's lymphoma<br>• Chronic myelogenous leukemia<br>• Hemoglobinopathy (ie Fanconi's syndrome, Thalassemia major)<br>• Myelodysplasia/myelodysplastic syndromes<br>• Severe combined immunodeficiency<br>• Severe or very severe aplastic anemia<br>• Amyloidosis | PPO: 10% of the Plan allowance (No Deductible)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You Pay<br>After the calendar year deductible… |
|---|---|
| **Organ/tissue transplants (cont.)** | |
| • Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)<br><br>Autologous transplants for:<br>• Acute lymphocytic or non-lymphocytic leukemia (i.e., myelogenous leukemia)<br>• Advanced Hodgkin's<br>• Anvanced non-Hodgkin's lymphoma<br>• Neuroblastoma<br>• Amyloidosis<br>• Multiple myeloma<br>• Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors<br>• Breast cancer<br>• Epithelial ovarian cancer<br><br>Autologous tandem transplants for:<br>• Recurrent germ cell tumors (including testicular cancer)<br>• Multiple myeloma<br>• De-novo myeloma | PPO: 10% of the Plan allowance (No Deductible)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |
| Note: We cover related medical and hospital expenses of the donor when we cover the recipient.<br><br>Note: All allowable charges incurred for a surgical transplant, whether incurred by the recipient or donor will be considered expenses of the recipient and will be covered the same as for any other illness or injury subject to the limits stated below. This benefit applies only if we cover the recipient and if the donor's expenses are not otherwise covered.<br><br>Transportation Benefit<br>• We will also provide up to $10,000 per covered transplant for transportation (mileage or airfare) to a Transplant Center of Excellence and reasonable temporary living expenses (i.e. lodging and meals) for the receipient and one other individual (or in the case of a minor, two other individuals), if the recipient lives more than 100 miles from the designated transplant facility.<br>• Transportation benefits are payable for follow-up care up to one year following the transplant. You must contact Customer Service for what are considered reasonable temporary living expenses.<br><br>Limited Benefits: | PPO: 10% of the Plan allowance (No Deductible)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You Pay<br>After the calendar year deductible… |
|---|---|
| **Organ/tissue transplants (cont.)** | |
| • The process for preauthorizing organ transplants is more extensive than the normal precertification process. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor must contact the Plan's Medical Management Program so we can arrange to review the clinical results of the evaluation and determine if the proposed procedure meets our definition of "medical necessary" and is on the list of covered transplants. Coverage for the transplant must be authorized in advance, in writing by the Plan's Medical Management Program. | PPO: 10% of the Plan allowance (No Deductible)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |
| • We will pay for a second transplant evaluation recommended by a physician qualified to perform the transplant, if: the transplant diagnosis is covered and the physician is not associated or in practice with the physician who recommended and will perform the organ transplant. A third transplant evaluation is covered only if the second evaluation does not confirm the initial evaluation.<br>• The transplant must be performed at a Transplant Center of Excellence to receive maximum benefits.<br>• If benefits are limited to $100,000 per transplant, included in the maximum are all charges for hospital, medical and surgical care incurred while the patient is hospitalized for a covered transplant surgery and subsequent complications related to the transplant. Outpatient expenses for chemotherapy and any process of obtaining stem cells or bone marrow associated with bone marrow transplant (stem cell support) are included in benefits limit of $100,000 per transplant. Tandem bone marrow transplants approved as one treatment protocol are limited to $100,000 when not performed at a Transplant Center of Excellence. Expenses for aftercare such as outpatient prescription drugs are not a part of the $100,000 limit. | PPO: 10% of the Plan allowance (No Deductible)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount(calendar year deductible applies)<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount<br><br>If prior approval is not obtained or a Transplant Center of Excellence is not used, our allowance will be limited for hospital and surgery expenses up to a maximum of $100,000 per transplant. If we cannot refer a member in need of a transplant to a designated facility, the $100,000 maximum will not apply. |
| • Chemotherapy and procedures related to bone marrow transplantation must be performed only at a Transplant Center of Excellence to receive maximum benefits.<br>• Simultaneous transplants such as kidney/pancreas, heart/lung, heart/liver are consider as one transplant procedure and are limited to $100,000 when not performed at a Transplant Center of Excellence. | PPO: 10% of the Plan allowance (No Deductible)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)<br><br>Out-of-network: 15% of the plan allowance and any difference between our allowance and the billed amount (No Deductible) |
| *Not covered:*<br>• *Services or supplies for or related to surgical transplant procedures (including administration of high-dose chemotherapy) for artificial or human organ/tissue transplants not listed as specifically covered.*<br>• *Donor screening tests and donor search expenses, except those performed for the actual donor*<br>• *Donor search expense for bone marrow transplants* | *All Charges.* |

| Benefit Description | You Pay<br>After the calendar year deductible… |
|---|---|
| **Anesthesia** | |
| Professional services provided in:<br>• Hospital (inpatient)<br>• Hospital outpatient department<br>• Skilled nursing facility<br>• Ambulatory surgical center<br>• Office | PPO: 10% of the Plan allowance (No Deductible)<br>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)<br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |

# Section 5(c). Services provided by a hospital or other facility, and ambulance services

**Important things you should keep in mind about these benefits:**

**• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.**

• In this Section, the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)".

• PPO benefits apply only when you reside in the PPO network area and use a PPO provider. When no PPO provider is available, non-PPO benefits apply. Out-of-network benefits apply when you reside outside the PPO network area.

• Be sure to read Section 4, Your costs for covered services for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

• The amounts listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Section 5(a) or (b).

**• YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

**TO OBTAIN THE MAXIMUM BENEFITS, YOU SHOULD GET PRECERTIFICATION OF CARE YOU RECEIVE IN SKILLED NURSING FACILITIES, HOSPICE, AND ALSO HOME HEALTH CARE.** Please refer to this section (Skilled nursing facility benefits and Hospice care) and Section 5(a) (Home health services) for details on how your benefits are affected if you do not certify. Also, please refer to Section 3 for additional details on precertification.

| Benefit Description | You Pay |
|---|---|
| **Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".** | |
| **Inpatient hospital** | |
| Room and board, such as<br>• semiprivate or intensive care accommodations;<br>• general nursing care; and<br>• meals and special diets.<br>Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, we base our payment on the average semiprivate rate of the most comparable hospital in the area.<br>• Operating, recovery, and other treatment rooms<br>• Rehabilitative services<br>• Prescribed drugs and medicines<br>• Diagnostic laboratory tests and X-rays<br>• Blood or blood plasma, if not donated or replaced<br>• Dressings, splints, casts, and sterile tray services | PPO: $150 copayment per hospital stay<br>Non-PPO: $350 copayment per hospital stay and 30% of the covered charges<br>Out-of-network: $200 copayment per hospital stay |

*Inpatient hospital - continued on next page*

| Benefit Description | You Pay |
|---|---|
| **Inpatient hospital (cont.)** | |
| • Medical supplies and equipment, including oxygen<br>• Anesthetics<br>Note: Take-home drugs are covered under Section 5(f).<br>Note: Take-home medical supplies, appliances, medical equipment, and any covered items billed by a hospital are covered under Section 5(a). | PPO: $150 copayment per hospital stay<br>Non-PPO: $350 copayment per hospital stay and 30% of the covered charges<br>Out-of-network: $200 copayment per hospital stay |
| *Not covered:*<br>• *Any part of a hospital admission that is not medically necessary (see definition in Section 10) such as when you do not need the acute hospital inpatient (overnight) setting but could receive care in some other setting without adversely affecting your condition or the quality of the medical care. Note: In this event, we pay benefits for services and supplies, excluding room and board and in -patient physician care, at the level of benefits that would have been covered if provided in another approved setting.*<br>• *Inpatient hospital services and supplies for surgery that we do not cover*<br>• *Custodial care (see definition) even when provided by a hospital*<br>• *Non-covered facilities, such as nursing homes, rest homes, places for the aged, convalescent homes or any place that is not a hospital, skilled nursing facility, or hospice*<br>• *Personal comfort items, such as radio, television, telephone, beauty and barber services*<br>• *Private nursing care*<br>• *Long term rehabilitative therapy* | *All Charges* |
| **Outpatient hospital or ambulatory surgical center** | |
| • Operating, recovery, and other treatment rooms<br>• Prescribed drugs and medicines for use in the facility<br>• X-ray, laboratory and pathology services, and machine diagnostic tests<br>• Administration of blood, blood plasma, and other biologicals<br>• Blood and blood plasma, if not donated or replaced<br>• Dressings, casts, and sterile tray services<br>• Medical supplies, including oxygen<br>• Anesthetics and anesthesia service<br>• Outpatient facility room charges<br>Note: Take-home drugs are covered under Section 5(f). | PPO: 10% of the Plan allowance (calendar year deductible applies)<br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)<br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies) |

*Outpatient hospital or ambulatory surgical center - continued on next page*

| Benefit Description | You Pay |
|---|---|
| **Outpatient hospital or ambulatory surgical center (cont.)** | |
| Note: Take-home medical supplies, appliances, medical equipment and any covered items billed by a hospital are covered under Section 5(a).<br><br>Note: We cover hospital services related to dental procedures (even though the dental procedure itself may not be covered) only when a nondental physical impairment exists that makes hospitalization necessary to safeguard your health. | PPO: 10% of the Plan allowance (calendar year deductible applies)<br><br>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies) |
| **Skilled nursing care facility benefits** | |
| If **precertified**, we cover semiprivate room, board, services and supplies in a Skilled Nursing Facility (SNF) for up to 90 days when:<br>1. Skilled Nursing Facility stay is medically necessary and<br>2. when the Skilled Nursing Facility is under the supervision of a physician | PPO: Charges in excess of 90-day maximum<br><br>Non-PPO: Charges in excess of 90-day maximum and any difference between our allowance and the billed amount<br><br>Out-of-network: Charges in excess of 90-day maximum and any difference between our allowance and the billed amount |
| If **not precertified**, we cover semiprivate room, board, services and supplies for up to 45 days subject to the above conditions<br><br>Note: Precertified and Nonprecertified days are combined. Day limit not to exceed 90 days per calendar year. | PPO: 20% and charges in excess of the 45-day maximum<br><br>Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount for 45 days, then all additional charges<br><br>Out-of-network: 20% of the Plan allowance and any difference between our allowance and the billed amount for 45 days, then all additional charges |
| *Not Covered: Custodial care* | *All Charges* |
| **Hospice care** | |
| Hospice is a coordinated inpatient and outpatient program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration<br><br>If **precertified,** we pay $7,500 for inpatient or outpatient hospice care | PPO: Charges in excess of $7,500 maximum<br><br>Non-PPO: Charges in excess of $7,500 maximum and the difference between the Plan allowance and the billed amount<br><br>Out-of-network: Charges in excess of $7,500 maximum and the difference between the Plan allowance and the billed amount |
| **If not precertified**, we pay $4,500 for inpatient or outpatient hospice care<br><br>Note: One hospice program is covered per lifetime. This benefit does not apply to services covered under any other provisions of the Plan.<br><br>Note: Precertified and Nonprecertified days are combined. Limit not to exceed $7,500. | PPO: Charges in excess of $4,500 maximum<br><br>Non-PPO: Charges in excess of $4,500 maximum and the difference between the Plan allowance and the billed amount<br><br>Out-of-network: Charges in excess of $4,500 maximum and the difference between the Plan allowance and the billed amount |

| Benefit Description | You Pay |
|---|---|
| **Ambulance** | |
| • Professional ambulance service (including air ambulance when medically necessary) to or from the nearest hospital equipped to handle your condition.<br>• Transportation by professional ambulance, railroad or commercial air line on a regularly scheduled flight to the nearest hospital equipped to furnish special and unique treatment when medically appropriate | 10% of Plan Allowance (calendar year deductible applies) |
| *Not covered:*<br>• *Ambulance transportation from hospital to home*<br>• *Ambulance transport for you or your family's convenience* | *All charges* |

# Section 5(d). Emergency services/accidents

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this Section. We added - (No Deductible) - to show when the calendar year deductible does not apply.
- PPO benefits apply only when you reside in the PPO network area and use a PPO provider. When no PPO provider is available, non-PPO benefits apply. Out-of-network benefits apply when you reside outside the PPO network area.
- Be sure to read Section 4, Your costs for covered services for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

**What is an accidental injury?**

An accidental injury is a bodily injury that requires immediate medical attention and is sustained solely through violent, external, and accidental means, such as broken bones, animal bites, insect bites and stings, and poisonings. Accidental dental injury is under Section 5(h).

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Note: The calendar year deductible applies to almost all benefits in this Section.<br>We say "(No deductible)" when it does not apply.** | |
| **Accidental injury** | |
| We pay 100% of the plan allowance after the listed copays for the following care you receive as a result of an accidental injury:<br>• Emergency room (ER) facility charge and ER physician's charge or<br>• Initial office visit for accidental injury<br>Note: We pay for services performed outside the ER facility under the appropriate Plan benefit.<br>Note: We pay for services in the ER, but billed separately from the hospital bill such as x-ray, laboratory, pathology and machine diagnostic tests under the appropriate Plan benefit (see Section 5 (a)).<br>Note: We pay Hospital benefits as specified in Section 5(c) if you are admitted to the hospital.<br>Note: We pay for services performed at the time of the initial office visit such as x-ray, laboratory tests, drugs or any supplies or other services under the appropriate Plan benefit (see Section 5 (a)). | PPO services in physician's office: Nothing (No Deductible).<br>PPO service **outside physician's office**: $50 copay per occurrence (No Deductible) (copay is waived if admitted to the hospital).<br>Non-PPO: $50 copay per occurrence and the difference between our allowance and the billed amount (No Deductible) (copay is waived if admitted to the hospital).<br>Out-of-network: Only the difference between our allowance and the billed amount (No Deductible). |

| Benefit Description | You pay<br>After the calendar year deductible… |
|---|---|
| **Medical emergency** | |
| Regular Plan benefits apply except for the copays listed on the right when you receive care because of a non- accidental medical emergency. See Section 5(a). | PPO services in physician's office: $10 copayment (No Deductible).<br><br>PPO services **outside physician's office:** $50 copay per occurrence and 10% of the Plan allowance (copay is waived if admitted to the hospital).<br><br>Non-PPO: $50 copay per occurrence and 30% of Plan allowance and any difference between our allowance and the billed amount (copay is waived if admitted to the hospital).<br><br>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount. |
| **Ambulance** | |
| • Professional ambulance service (including air ambulance when medically necessary) to or from the nearest hospital equipped to handle your condition.<br>• Transportation by professional ambulance, railroad or commercial air line on a regularly scheduled flight to the nearest hospital equipped to furnish special and unique treatment when medically appropriate | 10% of Plan Allowance |
| Not covered:<br>• *Ambulance transportation from hospital to home*<br>• *Ambulance transport for you or your family's convenience* | *All Charges* |

## Section 5(e). Mental health and substance abuse benefits

If you reside in the PPO Network Area, you may choose to get PPO or Non-PPO care. If you reside outside the network area, you will receive out-of-network care. PPO members who choose PPO care must get our approval for services and follow a treatment plan we approve. Cost-sharing and limitations for PPO or out-of-network mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions

**Important things you should keep in mind about these benefits:**

• All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

• The calendar year deductible is $300 per person ($600 per family) and applies to almost all benefits in this Section. We added - (No Deductible) - to show when the calendar year deductible **does not apply.**

• PPO benefits apply only when you reside in the PPO network area and use a PPO provider. When no PPO provider is available, non-PPO benefits apply. Out-of-network benefits apply when you reside outside the PPO network area.

• Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

**• PPO MEMBERS WHO CHOOSE PPO CARE MUST GET PREAUTHORIZATION OF THESE SERVICES. BENEFITS MAY BE REDUCED IF YOU FAIL TO GET PRECERTIFICATION OF THESE SERVICES. SEE THE INSTRUCTIONS AFTER THE BENEFITS DESCRIPTIONS BELOW.**

PPO mental health and substance abuse benefits are listed below, then Non-PPO and Out-of-network benefits begin on page 46.

| Benefit Description | You Pay<br>After the calendar year deductible… |
|---|---|
| **Note: The calendar year deductible applies to almost all benefits in this Section.<br>We say "(No deductible)" when it does not apply.** | |
| **In-Network benefits** | |
| All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.<br><br>Note: PPO benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan we approve. | Your cost sharing responsibilities are no greater than for other illnesses or conditions. |
| • Professional services provided by a physician<br>• Other professional services (i.e., psychologists, clinical social workers, licensed counselors), inpatient professional services, and outpatient hospital services<br>• Services in approved alternative care settings, such as partial hospitalization or facility-based intensive outpatient treatment (See definitions, Section 10).<br>• Diagnostic tests (including psychological testing) | PPO: 10% of the Plan allowance (No Deductible) |
| • Medical management<br><br>Note: We cover this under Section 5(a) pharmacological visits, no preauthorization is required. | PPO: $10 copayment (No Deductible) |

*In-Network benefits - continued on next page*

| Benefit Description | You Pay<br>After the calendar year deductible… |
|---|---|
| **In-Network benefits (cont.)** | |
| • Inpatient hospital charges (to include residential treatment centers) and other hospital services and supplies. | PPO: $150 co-payment per hospital stay (No Deductible) |
| *Not covered:*<br>• *Services we have not approved.*<br>• *All charges for chemical aversion therapy, conditioned reflex treatments, narcotherapy or any similar aversion treatments and all related charges (including room and board)*<br>• *Any provider not specifically listed as covered*<br>• *Counseling or therapy for marital, educational or behavioral problems, or related to mental retardation or learning disabilities*<br>• *Community-based programs such as self-help groups or 12 step program*<br>• *Services by pastoral (except in medically underserved areas), marital, or drug/alcohol counselors* | *All Charges* |
| Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another. | |

**Preauthorization and Precertification**

To be eligible to receive these enhanced mental health and substance abuse benefits, you must obtain a treatment plan and follow all of our network authorization processes. These include:

• Outpatient mental health and substance abuse benefits will be reduced by 50% if services are not preauthorized within two business days of the initial visit.

• Preauthorization and concurrent reviews are required for all levels of care in network.

• The medical necessity of your inpatient services (to include residential treatment care) must be precertified for you to receive full Plan benefits. Otherwise, the benefits payable will be reduced by $500. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. You, your representative, your physician, or your hospital must call The Plan's Disease Management Program prior to admission. The toll-free number is 1-888-234-4103.

You must provide the following information: enrollee's name and Plan identification number; patient's name, birth date and phone number; reason for hospitalization, proposed treatment; name of hospital or facility; name and number of admitting physician; and number of planned days of hospital stay.

**Network limitation**

We will reduce your benefits if you do not follow all of our preauthorization process and your treatment plan.

| Non-PPO and Out-of-Network benefits | You Pay |
|---|---|
| **Mental Health**<br>• Professional services by physicians, psychologists, clinical social workers or licensed counselors, and inpatient professional services | **Non-PPO**: 50% of the Plan allowance and any difference between our allowance and the billed amount and **all charges in excess of 50 visit maximum per calendar year** |

| | |
|---|---|
| | **Out-of-network**: 15% of the Plan allowance and the difference between our allowance and the billed amount |
| • Diagnostic testing (including psychological testing)<br>• Medical management | **Non-PPO**: 25% of the Plan allowance and the difference between our allowance and the billed amount<br>**Out-of-network**: 15% of the Plan allowance and the difference between our Plan and the billed amount |
| • Outpatient hospital charges | **Non-PPO**: 50% of the Plan allowance and the difference between our allowance and the billed amount<br>**Out-of-network**: 15% of the Plan allowance and the difference between our Plan and the billed amount |
| • Inpatient hospital charges (including residential treatment centers) and other hospital services and supplies. | **Non-PPO**: $350 copayment per hospital stay and 30% of the covered charges (No Deductible)<br>**Out-of-network**: $200 copayment per hospital stay (No Deductible) |
| • Services in approved alternative care settings, such as partial hospitalization or facility-based intensive outpatient treatment (See definitions, Section 10) | **Non-PPO**: 25% of the Plan allowance and any difference between our allowance and the billed amount<br>**Out-of-network**: 15% of the Plan allowance and any difference between our allowance and the billed amount |
| **Substance Abuse**<br>• Inpatient care includes room and board and ancillary charges for hospital stays in a treatment facility for rehabilitative treatment of alcoholism or substance abuse | **Non-PPO**: $350 copayment per hospital stay and 30% of the covered **charges up to the combined lifetime maximum of $25,000** (No Deductible) and all charges in excess of the combined lifetime maximum.<br>**Out-of-network**: $200 copayment per hospital stay (No Deductible) |
| • Outpatient benefits (including aftercare) | **Non-PPO**: 25% of the Plan allowance and the difference between our allowance and the billed amount **up to the combined lifetime maximum of $25,000** and all charges in excess of the combined lifetime maximum.<br>**Out-of-network**: 15% of the Plan allowance and the difference between our allowance and the billed amount |
| • Services in approved alternative care settings, such as partial hospitalization or facility-based intensive outpatient treatment (See definitions, Section 10.) | **Non-PPO**: 25% of the Plan allowance and any difference between our allowance and the billed amount<br>**Out-of-network**: 15% of the Plan allowance and any difference between our allowance and the billed amount |

| Non-PPO and Out-of-Network benefits | You Pay |
|---|---|
| *Not covered under mental health and substance abuse:*<br>• *Services we have not approved*<br>• *All charges for chemical aversion therapy, conditioned reflex treatments, narcotherapy or any similar aversion treatments and all related charges (including room and board)*<br>• *Any provider not specifically listed as covered*<br>• *Counseling or therapy for marital, educational or behavioral problems, or related to mental retardation or learning disabilities*<br>• *Community-based programs such as self-help groups or 12 step program*<br>• *Services by pastoral (except in medically underserved areas), marital, or drug/alcohol counselors* | *All Charges* |

**Lifetime maximum** Non-PPO inpatient or outpatient care for the treatment of alcoholism and drug abuse is limited to a lifetime maximum of $25,000.

**Precertification** Precertification of treatment programs is not required. The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive these benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits will be reduced by $500. See Section 3 for details. Precertification is not required for overseas care.

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your cost for covered services,* for information about catastrophic protection for these benefits
- Section 7, *Filing a claim for covered services*, for information about submitting non-PPO and Out-of-network claims

## Section 5(f). Prescription drug benefits

**Important things you should keep in mind about these benefits:**

- We cover prescribed drugs and medications, as described below.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Certain drugs require prior authorization or may be subject to quantity limits. If your prescription is for a drug requiring prior authorization, additional information from your physician will be needed before the medication is dispensed. Your physician may call 1-800-634-0069 to begin the review process.
- The calendar year deductible does not apply to almost all benefits in this Section. We added - (No Deductible) - to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

**Who can write your prescription.** A licensed physician or dentist must write the prescription.

**Where you can obtain them.** You may fill the prescription at a network pharmacy or by mail. To locate a network pharmacy in your area, call 1-800-752-0598 or you may also visit Compass Rose's website at www.CompassRoseBenefits.com. We will send you information on the mail order drug program. To use the program: 1) complete the initial mail order form; 2) enclose your prescription and copayment; 3) mail your order to Express Scripts, Inc., PO Box 8545 Bensalem, PA 19020-9381; 4) allow two to three weeks for delivery. You will receive forms for refills and future prescription orders each time you receive drugs or supplies under this program. If you have questions about the mail order program, call 1-800-752-0598.

**We use a formulary.** A formulary is a list of selected FDA-approved commonly prescribed medications from which your physician or dentist may choose to prescribe. The formulary is designed to inform you and your physician about quality medications that, when prescribed in place of other nonformulary medications, can help contain the increasing cost of prescription drug coverage without sacrificing quality. To find out if your medication is on the formulary, call Express Scripts, Inc., at 1-800-752-0598 or visit Compass Rose's website at www.CompassRoseBenefits.com. If you are prescribed a drug not on the formulary, you will pay a higher copayment. A request for a nonformulary appeal may be submitted in writing through the Disputed Claims Process as described in Section 8.

**Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

**Some drugs require prior authorization.** Prior Authorization Requirements (PAR) are applied to encourage appropriate use of medications that are most likely to have certain risk factors. These requirements apply to drugs that may be used in amounts that exceed dosage or length of treatment recommendations or that may be more costly than medications that are proven to be clinically and therapeutically similar. If your prescription is identified as a drug requiring PAR, your physician should call Customer Service at 1-800-634-0069.

**These are the dispensing limitations.** When you obtain prescription drugs from a pharmacy using your Prescription Drug Card, you may obtain up to a 30-day supply of covered drugs. If purchasing more than a 30-day supply on the same day, any expense exceeding that supply limit will not be covered through the pharmacy arrangement. You may purchase your covered prescription drugs and supplies by presenting your prescription drug card and your prescription to a participating provider. Prescription refills will be covered when no more than 50% of the 30-day supply remains based on your physician's prescription.

If your physician or dentist prescribes a medication that will be taken over an extended period of time, you should request two prescriptions, one for immediate use with a participating retail pharmacy and the other for up to a 90-day supply from the Mail Order Program. All drugs and supplies covered by the Plan are available under this program except fertility drugs. If you have questions about a particular drug or a prescription, and to request your first order forms, call 1-800-752-0598. If a generic equivalent to the prescribed drug is available, Express Scripts will dispense the generic equivalent instead of the brand name unless you or your physician specifies that the brand name is required. When purchasing drugs at a pharmacy, you must use your prescription drug card. Please call us to request additional cards for family members.

| Benefits Description | You Pay<br>After the calendar year deductible... |
|---|---|
| **Note: The calendar year deductible applies to almost all benefits in this Section.<br>We say "(No deductible)" when it does not apply.** | |
| **Covered medications and supplies** | |
| You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail:<br><br>• Drugs, vitamins and minerals that by Federal law of the United States require a doctor's prescription for their purchase<br><br>• Insulin and diabetic supplies<br><br>Note: Members with diabetes that have Medicare B as their primary insurer, must obtain their testing supplies through a Diabetic supplier that coordinates benefits with Medicare. Please call the number on the back of your insurance card for assistance in identifying a supplier.<br><br>• FDA-approved drugs and devices requiring a physician's prescription for the purpose of birth control<br><br>• Needles and syringes for the administration of covered medications<br><br>Here are some things to keep in mind about our prescription drug program:<br><br>• A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. Your physician must specify "dispense as written" if a brand name drug is required.<br><br>• We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. To order a prescription drug formulary, call Customer Service at 1-800-752-0598.<br><br>Compound prescription drugs are covered as Tier 3 drugs. | **Network Retail:**<br><br>Tier 1: $5 (No Deductible)<br><br>Tier 2: $30 (No Deductible)<br><br>Tier 3: 30% or $45, whichever is greater (No Deductible)<br><br>**Network Retail when Medicare Part B is primary:**<br><br>Tier 1: $3 (No Deductible)<br><br>Tier 2: $18 (No Deductible)<br><br>Tier 3: 30% or $35, whichever is greater (No Deductible)<br><br>**Network Mail Order:**<br><br>Tier 1: $10 (No Deductible)<br><br>Tier 2: $60 (No Deductible)<br><br>Tier 3: 30% or $90, whichever is greater (No Deductible)<br><br>**Network Mail Order when Medicare Part B is primary:**<br><br>Tier 1: $6 (No Deductible)<br><br>Tier 2: $36 (No Deductible)<br><br>Tier 3: 30% or $45, whichever is greater (No Deductible)<br><br>**Note: If there is no generic equivalent available, you will still have to pay the Tier 2 copay.**<br><br>When purchasing drugs at a pharmacy, you must use your Health Insurance Card. |
| Medications to treat severe, chronic medical conditions and are usually administered by injection or infusion in the following categories:<br><br>• Antihemophilic factors such as Helixate FS, Recombinate | 5% up to maximum of $150 per 30 day supply (No Deductible) |

*Covered medications and supplies - continued on next page*

| Benefits Description | You Pay<br>After the calendar year deductible... |
|---|---|
| **Covered medications and supplies (cont.)** | |
| • Blood growth factors such as Aranesp, Leukine, Neupogen, Procrit<br>• Calcimimetic Agent such as Sensipar<br>• Growth Hormone medications such as Genotropin, Humatrope, Nutropin<br>• Immunoglobulin preparations such as, Gamunex, Iveegam<br>• Immunosuppressives such as Amevive, Copaxone, Raptiva<br>• Interferons such as Avonex, Betaseron, Intron A, Pegasys, Peg-Intron<br>• Interleukin-Receptor Antagonist sush as Kineret<br>• Monoclonal antibody such as Synagis, Xolair<br>• Mucolytic Enzyme such as Pulmozyme<br>• Platelet Aggregation Inhibitor such as Remodulin<br>• Prostaglandin drugs such as Flolan<br>• Synthetic Nucleoside Analog such as Copegus, Rebetol, Ribavirin<br>• Tumor necrosis factor modulators such as Enbrel, Humira<br><br>Drugs in these categories are subject to the Specialty Pharmacy Benefits. The medication examples provided are not all inclusive. Call our customer service department at 1-800-634-0069 to determine if other medications not listed apply to this benefit. | 5% up to maximum of $150 per 30 day supply (No Deductible) |
| **Obtaining Specialty Medication under the Plan:**<br><br>Please refer to your drug plan formulary to determine if the drug you have been prescribed by your physician needs to be filled by one of the plan's Specialty Pharmacy providers.<br><br>If your medication has been identified as being a specialty medication, you will be required to call the number on the back of your insurance card for instructions on how to arrange the filling and delivery of your specialty medication.<br>• Medications will be mailed to you at no additional cost<br>• For safety, all mailing will be shipped based on temperature requirements and considerations<br>• Specialty Medications cannot be obtained through the traditional 90-day mail order program<br>• **Unless on an emergency basis, the plan will not pay for Specialty Medications through the retail pharmacy.** | 5% up to maximum of $150 per 30 day supply (No Deductible) |

*Covered medications and supplies - continued on next page*

| Benefits Description | You Pay<br>After the calendar year deductible... |
|---|---|
| **Covered medications and supplies (cont.)** | |
| Specialty Medications are injectable and oral medications that are used to treat chronic health conditions including but not limited to such conditions as transplant recipients, immunological conditions, growth hormone, bleeding disorder, HIV/AIDS. | 5% up to maximum of $150 per 30 day supply (No Deductible) |
| If you reside outside of the United States and do not order prescription drugs through the Mail Order Prescription Drug Program:<br><br>If you are provided drugs, including specialty pharmacy drugs, directly by a physician or covered facility (not a pharmacy), including FDA-approved drugs and devices requiring a physician's prescription for the purpose of birth control:<br><br>If you do not use your prescription drug card to purchase needles and syringes for the administration of covered medications or diabetic supplies:<br><br>If you purchase colostomy or ostomy supplies: | 20% of the total cost of the drug |
| *Not covered:*<br>• *Drugs and supplies for cosmetic purposes*<br>• *Nutritional supplements and vitamins (including prenatal) that do not require a prescription*<br>• *Medication that does not require a prescription under Federal law even if your physician prescribes it or a prescription is required under your State law*<br>• *Medical supplies such as dressings and antiseptics*<br>• *Medication for which there is a non-prescription equivalent available Prescriptions received from non-participating pharmacies unless overseas or through a covered physician or facility. (Call 1-800-752- 0598 to locate a participating pharmacy.)*<br>• *Drug copayments*<br>• *Fertility drugs are covered only under "Infertility services"* | *All Charges* |

# Section 5(g). Dental benefits

**Important things you should keep in mind about these benefits:**

• If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.

• Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

• The calendar year deductible does not apply to the benefits in this Section. We added - (No Deductible) - to show that the calendar year deductible does not apply.

• Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

**Note: Even when the dental procedure itself may not be covered, we cover hospitalization for dental procedures when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for outpatient hospital benefits.**

| Accidental injury benefit | You Pay |
|---|---|
| **Accidental injury benefit** | |
| We cover outpatient restorative services necessary to promptly repair (but not replace) sound natural teeth until treatment is completed.<br><br>The need for these services must result from an accidental injury from an external force such as a blow or fall that requires immediate attention (not from biting or chewing). | 20% of the Plan allowance and any difference between our allowance and the billed amount (No Deductible) |

| Dental Benefits | | |
|---|---|---|
| **Service** | **We pay (scheduled allowance)** | **You Pay** |
| Routine oral examinations including x-rays, cleaning, diagnosis, and preparation of a treatment plan | $39 twice per year | All charges in excess of the scheduled amounts listed to the left (No Deductible) |
| **Dental fillings:** | | |
| • One Surface | $12 | |
| • Two Surface: | $19 | |
| • Three or more surfaces: | $24 | |

*Not Covered*

- *Dental appliances, study models, splints, and other devices or dental services associated with the treatment of temporomandibular joint (TMJ) dysfunction*
- *Root canals and Crowns (except for accidental dental injury benefit)*
- *Other dental services not listed as covered*

*Note: Surgical removal of impacted teeth is covered in Section 5(b).*

## Section 5(h). Special features

| Special feature | Description |
|---|---|
| **Centers of Excellence** | The Plan has special arrangements with facilities to provide services for tissue and organ transplants. The network was designed to give you an opportunity to access providers that demonstrate high quality medical care for transplant patients. For additional information regarding our transplant network, please call 1-888-234-4103. |
| **Medical Management** | This Plan offers a medical management program for members and covered dependents with diabetes, heart failure, asthma, coronary artery disease, or chronic obstructive pulmonary disease. Your health is important to us! If you or your covered dependent has any of the above, you will be contacted to voluntarily participate.<br><br>If you would like more information about this program, please call your plan at 1-888-234-4103. |
| **Flexible Benefits Option** | Under the flexible benefits option, we determine the most effective way to provide services.<br>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue.<br>• Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process.<br>• By approving an alternative benefit, we cannot guarantee you will get it in the future.<br>• The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits.<br>• If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request.<br>• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. |
| **Glucose Monitors** | If you are diagnosed with diabetes, you may receive a free glucose monitor. The monitor is a small device that diabetics use to check and monitor their blood sugar. Monitoring and controlling blood sugars is essential for managing diabetes and preventing unnecessary complications.<br><br>To obtain a glucose monitor, call 1-800-634-0069 |
| **Healthy Maternity Program** | You have access to a Healthy Maternity Program, which provides educational material and support to pregnant women. Contact Customer Service at 1-888-234-4103 for more information. |
| **Lifestyle Prescription Medications** | Many lifestyle prescription drugs are available at a discounted rate through participating pharmacies and the Plan's mail order program. You are responsible for the entire cost of the drugs; however, they are available to you at our preferred contracted rate. The following lifestyle prescription drugs are covered under this benefit:<br><br>**Cosmetic**: Renova, Vaniqua, Propecia<br><br>**Infertility**: A.P.L., Chorex-5, Chorex-10, Chronon 10, Clomid, Clomiphene, Crinone gel, Fertinex, Follistem, Gonal-F, Gonic, HCG, Humegon, Pergonal, Pregnyl, Profasi, Repronex, Serophone |

| | |
|---|---|
| | **Obesity**: Adipost, Didrex, Ionamin, Merida, Phendimetrazine, Phenter mine, Sanorex, Tenuate, Xenical<br><br>**Sexual Dysfunction:** Caverject, Edex, Muse, Viagra<br><br>This list is subject to change and may be subject to medical necessity review if they are covered under another benefit provision (i.e., Infertility).<br><br>If you have a question on drug coverage, call 1-800-634-0069. |
| **Services Overseas** | Our overseas customers receive the same out-of-network benefits and prompt customer service as their stateside counterparts. There is no additional claims processing time for foreign claims |
| **The Lab Card Program** | The Lab Card program gives you and your dependents the option of receiving 100%, covered outpatient laboratory testing if your doctor sends your lab work to LabOne for processing.<br><br>Lab Card is an optional program. If you choose not to use Lab Card, you will not be penalized. You will simply pay the deductible, coinsurance or copay portion of your lab work.<br><br>Lab Card does not replace your current healthcare benefits; it simply gives you and your dependents the option of receiving 100% coverage for outpatient laboratory testing.<br><br>Lab Card covers most outpatient laboratory testing included in your health insurance plan, provided the tests have been ordered by a physician and processed at LabOne. Outpatient lab work includes: Blood testing (e.g., cholesterol, CBC), Urine testing (e.g., urinalysis), Cytology and pathology (e.g., pap smears, biopsies), Cultures (e.g., throat culture).<br><br>Lab Card does not cover: Lab work ordered during hospitalization, Lab work needed on an emergency (STAT) basis and time sensitive, esoteric outpatient laboratory testing such as fertility testing, bone marrow studies and spinal fluid tests, Non laboratory work such as mammography, X-ray, imaging and dental work.<br><br>When Medicare is primary, the LabCard does not apply. |

# Section 5(i). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidlines. For additional information contact the plan at 1-800-769-6953, or visit our website at www.compassrosebenefits.com.

**Best Doctors**

How can Best Doctors Help You? If you or a covered family member is diagnosed with a serious medical condition or suffer a serious trauma, Best Doctors offers you and the doctor an opportunity to consult with some of the world's top medical specialists. They will review your medical records, confirm your diagnosis and recommend specific treatment.

Our contact with Best Doctors can help you with most serious medical conditions, including; AIDS, Kidney Failure, Cancer, Heart Conditions, Multiple Sclerosis, Paralysis, Parkinson's Disease, Organ Transplant, Motor Neuron Disease, Alzheimer's Disease, Severe Burns, Stroke or Coma.

**CAREington Network**

The CAREington Network offers a variety of discounts to include:

Supplemental Dental

- CAREington POS Dental Network

1. Over 26,000 dental locations nationwide.

2. Save 20% - 50% on everything from general dentistry and cleaning to root canals, crowns and orthodontia.

3. 20% savings for specialists.

- Aetna Dental Access Network

1. Over 62,000 available dental practice locations nationwide.

2. Save an average of 30% - 50% on everything from general dentistry and cleaning to root canals, crowns and orthodontia.

**Supplemental Vision Care**

- Amerisight –LASIK Vision Correction Surgery

1. You will pay a nationally contracted rate of $935.00 per eye. If an additional procedure called custom LASIK is required, you will pay an additional $405 per eye.

2. The entire program will be explained to you and any questions you have will be answered when you call 1-888-582-6696 to take advantage of the plan.

- EyeMed – PLAN D

1. 40,000 providers at over 18,500 locations.

2. 15% - 45% Savings.

- VSP – Access Plan

1. Eye Examination: A discount of 20% off of the Member Doctor's Usual and Customary fee.

2. Frames & Lenses: A discount of 20% off of the Member Doctor's Usual and Customary fee.

3. Contact Lenses: A discount of 15% off of the Member Doctor's Usual and Customary fee.

**Supplemental Podiatry**

- DPM

1. Provider Network: 3,500

2. Discount Range: 50% discount on the provider's usual & customary exam fee, 20% discount on the provider's usual & customary fee for all other services and products.

**Supplemental Alternative Medicine**

- Axia Health Management

1. 28,000 Network Providers.

2. 10% - 30% discount on chiropractic & alternative medicine.

3. 25% discounts on vitamins & supplements.

4. Discounted services include: Acupuncture, Bio Feedback, Chiropractic, Dieticians, Exercise Specialists, Herbology/Herbal Medicine, Holistic Health Practitioners, Massage Therapy, Meditation, Nutritional Counseling, Nutritional Supplements, Reflexology, Relaxation Treatment, Tai Chi/Chi Gong, Vitamins and Yoga.

**Supplemental Hearing**

- HearPO

1. Provider Network: Over 1,600

2. Discount Range: 30% on hearing exams and services, 30%-62% on all hearing aids at any HearPO provider.

- Miracle-Ear

1. Provider Network: 1,000

2. Discount Range: 15% discount on hearing aids and repairs.

3. Free hearing evaluations and exams.

4. 30 day trial period with 100% money-back guarantee.

5. Locate a hearing provider at 1-800-456-6801 or at www.cmccare.com

**Long Term Care Insurance**

When you or a family member requires assistance with normal daily activities due to aging or a disabling accident or illness, you may require long-term care assistance. These situations can quickly deplete your family's lifetime savings. Genworth Life Insurance Company can provide Long Term Care insurance to guard against this circumstance.

Long Term Care insurance can:

- Cover the care and services you need if you have a chronic illness or disability that leaves you unable to care for yourself for an extended period of time.
- Can help keep you independent and help safeguard your savings from long-term care expenses.
- Can help you pay the expenses of long-term care when you are no longer able to care for yourself and must rely on others to provide assistance to you.
- Can typically help pay for facility care or home or adult daycare.

For additional information on any of these programs, please call 1-800-769-6953

**NON-FEHB Benefits are not part of the FEHB contract.**

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition (see specifics regarding transplants).** The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not make it medically necessary or eligible for coverage under this plan.

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- 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;
- Services, drugs, or supplies related to sex transformations, sexual dysfunction or sexual inadequacy;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.
- Any portion of a provider's fee or charge that has been waived. If a provider routine waives (does not require you to pay) a deductible, copayment or insurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived).
- Charges you or the Plan has no legal obligation to pay, such as excess charges for an annuitant 65 years or older who is not covered by Medicare Part A and/or Part B, physician charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge), or State premium taxes however applied;
- Services, drugs, or supplies for which you would not be charged if you had no health insurance coverage;
- Services, drugs or supplies related to weight control or any treatment of obesity except surgery for morbid obesity as described in Section 5(b);
- Services and supplies furnished or billed by a noncovered facility; however, medically necessary prescription drugs are covered; and
- Services, drugs or supplies you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister by blood, marriage or adoption.
- The Plan does not cover expenses related to medical records submission if the medical records are needed to process a claim. If medical records are inappropriately requested, the charges can be covered.

Listed below are examples of some of our exclusions:

- Acupuncture, except when used as an anesthetic agent for covered services;
- Biofeedback, conjoint therapy, hypnotherapy, milieu therapy, and interpretation/preparation of reports;
- Charges for completion of reports or forms;
- Charges for interest on unpaid balances;
- Charges for missed or cancelled appointments;
- Charges for telephone consultations, conferences, or treatment, mailings, faxes, emails or any other communication to or from a hospital or covered provider.
- Custodial care;

- Mutually exclusive procedures. These are procedures that are not typically provided to you on the same date of service;
- Non-medical services such as social services, recreational, educational, visual and nutritional counseling;
- Non-surgical treatment of temporomandibular joint (TMJ) dysfunction including dental appliances, study models, splints and other devices;
- Services, drugs or supplies not specifically listed as covered; and
- Treatment for learning disabilities and mental retardation.

Note: Exclusions that are primarily identified with a specific benefit category may also apply to other categories.

# Section 7. Filing a claim for covered services

**How to claim benefits**

To obtain claim forms, claims filing advice or answers about our benefits, contact us at 1-800-634-0069.

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-800-634-0069.

When you must file a claim—such as for services you received overseas or when another group health plan is primary—submit it on the HCFA-1500 or a claim form that includes the information shown below. Itemized bills and receipts should be sent to Association Benefit Plan, PO Box 668587, Charlotte, NC 28266-8587

• Name of patient and relationship to enrollee;

• Plan identification number of the enrollee;

• Name and address of person or firm providing the service or supply;

• Dates that services or supplies were furnished;

• Diagnosis;

• Type of each service or supply; and

• The charge for each service or supply.

You should use the Plan's standard claim form to file dental claims. Attach the dentist's itemized bill. The bill must include the name of the patient, dates of service, itemized charges and the dentist's tax ID number.

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

In addition:

- Generally, you need to fill out only one claim form per year. You should fill out a claim form if you submit a claim due to accidental injury, you have changed your address, or if the member's other insurance/Medicare status has changed.
- You must send a copy of the explanation of benefits (EOB) form you received from any primary payer (such as the Medicare Summary Notice (MSN)) with your claim. See Section 9 for Medicare claims.
- Bills for home nursing care must show that the nurse is a Registered (R.N.) or Licensed Practical Nurse (L.P.N.). You should also include the initial history and physical, treatment plan indicating expected duration and frequency from your attending physician and the nursing notes from the nurse.
- Claims for rental or purchase of durable medical equipment must include the purchase price, a prescription and a statement of medical necessity including the diagnosis and estimated length of time needed.
- Claims for physical, occupational, and speech therapy must include an initial evaluation and treatment plan indicating length of time needed for therapy and progress (therapy) notes for each date of service from the therapist.
- Claims for dental services must include a copy of the dentist's itemized bill (including the information required above) and the dentist's Federal Tax I.D. Number. We do not have separate dental claim forms.

| | |
|---|---|
| **Records** | Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements. |
| **Deadline for filing your claim** | Send us all of the documents for your claim as soon as possible. You must submit the claim within 90 days after you incur the expense, but in no event later then 2 years from the date you incure the expense. We can extend this deadline if you were prevented from filing your claim timely by administrative operations of Government or legal incapacity, provided you file the claim as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks. |
| **Foreign claims** | For covered services you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, you must send a completed claim form and the itemized bills.<br><br>Foreign claims for prescription drugs and supplies that are not ordered through the Mail Order Prescription Drug Program must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date, and charge.<br><br>Claims for foreign services should include an English translation.<br><br>Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred. |
| **When we need more information** | Annually you may be asked to verify other health care coverage. We may delay processing or deny benefits for your claim if you do not respond. |

## Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3:

| Step | Description |
|---|---|
| **1** | Ask us in writing to reconsider our initial decision. You must:<br>a) Write to us within 6 months from the date of our decision; and<br>b) Send your request to us at: Association Benefit Plan, PO Box 668587, Charlotte, NC 28266- 8587*;* and<br>c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and<br>d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. |
| **2** | We have 30 days from the date we receive your request to:<br>a) Pay the claim (or arrange for the health care provider to give you the care); or<br>b) Write to you and, if applicable, maintain our denial -- go to step 4; or<br>c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request -- go to step 3. |
| **3** | You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.<br>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.<br>We will write to you with our decision. |
| **4** | If you do not agree with our decision, you may ask OPM to review it.<br>You must write to OPM within<br>• 90 days after the date of our letter upholding our initial decision; or<br>• 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or<br>• 120 days after we asked for additional information.<br>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.<br>Send OPM the following information:<br>• A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;<br>• Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;<br>• Copies of all letters you sent to us about the claim;<br>• Copies of all letters we sent to you about the claim; and<br>• Your daytime phone number and the best time to call.<br>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. |

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

**5** OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

**Note: If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-888-234-4103 and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 2 at 202-606-3818 between 8 a.m. and 5 p.m. eastern time.

# Section 9. Coordinating benefits with other coverage

**When you have other health coverage**

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

**What is Medicare?**

Medicare is a health insurance program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

Please refer to page 16 for information about how we provide benefits when you are age 65 or older and do not have Medicare.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

**Claims process when you have the Original Medicare Plan:** You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claims, call us at 1-800-634-0069.

We waive some costs when the Original Medicare Plan is your primary payer. We will waive some out-of-pocket costs, as follows:

• If you are enrolled in Medicare Part B, we will waive copayments and coinsurance for medical services and supplies provided by physicians and other health care professionals. We will also waive deductibles and coinsurance for extended dental treatment for accidental dental injuries.

• If you are enrolled in Medicare Part A, we will waive hospital copayments and coinsurance.

- **Private contract with your physician**

A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You may be responsible for paying the difference between the billed amount and the amount we paid; under Medicare Advantage Part C.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

**This Plan and our Medicare Advantage plan:**

**This Plan and another plan's Medicare Advantage plan:** You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

**Suspended FEHB coverage to enroll in a Medicare Advantage plan**: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

| Primary Payer Chart | | |
|---|---|---|
| **A. When you - or your covered spouse - are age 65 or over and have Medicare and you...** | **The primary payer for the individual with Medicare is...** | |
| | **Medicare** | **This Plan** |
| 1) Have FEHB coverage on your own as an active employee | | ✓ |
| 2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant | ✓ | |
| 3) Have FEHB through your spouse who is an active employee | | ✓ |
| 4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above | ✓ | |
| 5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and... | | |
| • You have FEHB coverage on your own or through your spouse who is also an active employee | | ✓ |
| • You have FEHB coverage through your spouse who is an annuitant | ✓ | |
| 6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above | ✓ | |
| 7) Are enrolled in Part B only, regardless of your employment status | ✓ for Part B services | ✓ for other services |
| 8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more | ✓* | |
| **B. When you or a covered family member...** | | |
| 1) Have Medicare solely based on end stage renal disease (ESRD) and... | | |
| • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)** | | ✓ |
| • It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD | ✓ | |
| 2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... | | |
| • This Plan was the primary payer before eligibility due to ESRD **(for 30 month coordination period)** | | ✓ |
| • Medicare was the primary payer before eligibility due to ESRD | ✓ | |
| 3) Have Temporary Continuation of Coverage (TCC) and... | | |
| • Medicare based on age and disability | ✓ | |
| • Medicare based on ESRD **(for the 30 month coordination period)** | | ✓ |
| • Medicare based on ESRD **(after the 30 month coordination period)** | ✓ | |
| **C. When either you or a covered family member are eligible for Medicare solely due to disability and you...** | | |
| 1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee | | ✓ |
| 2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant | ✓ | |
| **D. When you are covered under the FEHB Spouse Equity provision as a former spouse** | ✓ | |

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

**TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and the retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

**Suspended FEHB coverage to enroll in TRICARE or CHAMPVA:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally, you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

**Workers' Compensation**

We do not cover services that:

• You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or

• OWCP or a similar agency pays for through a third party injury settlement or other similar preceding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

**Medicaid**

When you have this Plan and Medicaid, we pay first.

**Suspended FEHB coverage to enroll in Medicaid or a similar State- sponsored program of medical assistance.** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

**When other Government agencies are responsible for your care**

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

**When others are responsible for injuries**

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

**When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)**

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan,

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

## Section 10. Definitions of terms we use in this brochure

**Admission** The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.

**Assignment** Your authorization for the Plan to issue payment of benefits directly to the provider. We reserve the right to pay the member directly for all covered services.

**Calendar year** January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

**Coinsurance** Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 13

**Congenital anomalies** A condition existing at or from birth that is a significant deviation from the common form or anomaly norm. For purposes of this Plan, congenital includes protruding ear deformities, cleft lips, cleft palates, webbed fingers or toes, and other conditions that we may determine to be congenital anomalies. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structures supporting the teeth.

**Copayment** A co-payment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive covered services. See page 13.

**Cosmetic surgery** Any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through a change in bodily form.

**Cost-sharing** Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the coverd care you receive.

**Covered services** Services we provide benefits for, as described in this brochure.

**Custodial care** Treatment or services, regardless of who recommends them or where they are provided, that could be provided safely and reasonably by a person who is not medically skilled, or are designed mainly to help the patient with daily living activities. These activities include but are not limited to:

1) personal care such as help in: walking; getting in or out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;

2) homemaking, such as preparing meals or special diets;

3) moving the patient;

4) acting as a companion or sitter;

5) supervising medication that can usually be self administered; or

6) treatment services such as recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

Custodial care that lasts 90 days or more is sometimes known as Long Term Care.

**Deductible** A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 13.

**Effective date** The date the benefits described in this brochure are effective:

1. January 1 for continuing enrollments and for all annuitant enrollments;
2. the first day of the first full pay period of the new year for enrollees who change plans or options or elect FEHB coverage during Open Season for the first time; or

3. for new enrollees during the calendar year, but not during Open Season, the effective date of enrollment as determined by your employing office or retirement system.

**Expense**

The cost incurred for a covered service or supply ordered or prescribed by a covered provider. You can incur an expense on the date the service or supply is received. Expense does not include any charge:

1. for a service or supply that is not medically necessary; or
2. that is in excess of the Plan's allowance for the service or supply.

**Experimental or investigational services**

A drug, device, or biological product is experimental or investigational if it cannot lawfully be marketed without approval of the U.S. Food and Drug Administration (FDA), and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

**Group health coverage**

Health care coverage that you are eligible for because of employment, membership in, or connection with, a particular organization or group that provides payment for hospital, medical or other health care service or supplies, or that pays a specific amount for each day or period hospitalization.

**Home health care agency**

A public or private agency or organization appropriately licensed, qualified and operated under the law of the state in which it is located.

**Home health care plan**

A written plan, approved in writing by a physician, for continued care and treatment for a Plan member who is under the care of a physician and who would need a continued stay in a hospital or skilled nursing facility with the home health care.

**Hospice care program**

A coordinated program of home and inpatient pain control and supportive care for the terminally ill patient and the patient's family. Care is provided by a medically supervised team under the direction of an independent hospice administration that we approve.

**Hospital stay**

An admission (or series of admissions separated by less than 60 days) to a hospital as an inpatient for any one illness or injury. There is a new hospital stay when an admission is:

1. for a cause entirely unrelated to the cause for the previous admission;
2. for an enrolled employee who returns to work for at least one day before the next admission; or
3. for a dependent or annuitant when hospital stays are separated by at least 60 days.

| | |
|---|---|
| **Intensive Outpatient Program (IOP)** | A program that offers time-limited services that are coordinated, structured, and intensively therapeutic. Such programs are designed to treat a variety of individuals with moderate to marked impairment in at least one area of daily life resulting from psychiatric or addictive disorders. At a minimum, IOPs offer three to four hours of active treatment per day at least two to three days per week. |
| **Long term rehabilitation therapy** | Physical, speech, and occupational therapy which can be expected to last longer than a two-month period in order to achieve a significant improvement in your condition. |
| **Medical necessity** | Services, drugs, supplies, or equipment provided by a hospital or covered provider of health care services that we determine:<br><br>1) are appropriate to diagnose or treat your condition, illness or injury;<br><br>2) are consistent with standards of good medical practice in the United States;<br><br>3) are not primarily for the personal comfort of the patient, the family, or the provider;<br><br>4) are not a part of or associated with the scholastic education or vocational training of the patient; and<br><br>5) in the case of inpatient care, cannot be provided safely on an outpatient basis.<br><br>The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not in itself make it medically necessary. |
| **Mental conditions/ substance abuse** | Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD to be determined by the Plan; or disorders listed in the ICD requiring treatment for abuse of or dependence upon substances such as alcohol, narcotics, or hallucinogens. |
| **Partial hospitalization** | A time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services with a stable therapeutic environment. It provides 20 hours of scheduled programming, extended over a minimum of five days per week, by a licensed or JCAHO accredited facility |
| **Plan allowance** | Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows:<br><br>Twice a year the Healthcare Charges Database (HCD) compiles actual claims received in each Zip Code area throughout the United States. HCD guides are applied at the 90th percentile to surgery, physician services, therapy, X-ray and lab expenses.<br><br>We generally do not reduce overseas claims to a Plan allowance. However, we reserve the right to request information that will enable us to determine an allowance on charges that we deem to be excessive.<br><br>PPO providers accept the plan allowance as payment in full.<br><br>For more information, see Section 4, Differences between our allowance and the bill. |
| **Prosthetic device** | An artificial substitute for a missing functional body part (such as an arm or leg) because the body part is permanently damaged, is absent or is malfunctioning. |
| **Routine physical examination** | A complete evaluation, including a comprehensive history and physical examination, without symptoms or illness. |
| **Routine testing/screening** | Healthcare services you receive from a covered provider without any apparent signs or symptoms of an illness, injury or disease. |

| | |
|---|---|
| **Sound natural tooth** | A tooth that is whole or properly restored and is without impairment, periodontal, or other conditions and is not in need of the treatment provided for any other reason other than an accidental injury. |
| **Us/We** | Us and we refer to the Association Benefit Plan. |
| **You** | You refers to the enrollee and each covered family member. |

# Section 11. FEHB Facts

## Coverage information

**No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

**Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- What happens when your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

**Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

**Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

**When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2009 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2008 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

**When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

## When you lose benefits

**When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuation of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

**Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Employees Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

**Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

**Enrolling in TCC.** Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

**Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

**Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program.* See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

# Section 12. Three Federal Programs complement FEHB benefits

**Important information**

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

**The Federal Flexible Spending Account Program – *FSAFEDS***

**What is an FSA?**

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimburses. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** –Pays for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

**Where can I get more information about FSAFEDS?**

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

**The Federal Employees Dental and Vision Insurance Program – *FEDVIP***

**Important Information**

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program has no pre-existing condition limitations. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Premiums are withheld from salary on a pre-tax basis.

**Dental Insurance**

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period.

**Vision Insurance**

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

**Additional Information**

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

**How do I enroll?**

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888- 3337 (TTY number, 1-877-889-5680).

### The Federal Long Term Care Insurance Program – *FLTCIP*

**It's important protection**

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.


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Preferred Provider Organization (PPO).....6
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**X-rays**.....19

# Summary of benefits for the Association Benefit Plan - 2009

**Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the $300 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

| High Option Benefits | You pay | Page |
|---|---|---|
| **Medical services provided by physicians:** | PPO: $10 co-payment (No deductible) | 20 |
| | Non-PPO: 30% of our allowance | |
| | Out-of-network: 15% of our allowance | |
| **Diagnostic and treatment services provided in the office** | PPO: $10 co-payment (No deductible) | 20 |
| | Non-PPO: 30% of our allowance | |
| | Out-of-network: 15% of our allowance | |
| **Services provided by a hospital:** | | |
| • **Inpatient** | PPO: $150 hospital stay (No deductible) | 36 |
| | Non-PPO: $350 hospital stay and 30% of charges (No deductible) | |
| | Out-of-network: $200 hospital stay (No deductible) | |
| • **Outpatient** | PPO: 10% of our allowance | 37 |
| | Non-PPO: 30% of our allowance | |
| | Out-of-network: 15% of our allowance | |
| **Emergency benefits:** | | |
| • **Accidental Injury**<br>• For Emergency Room (ER) facility charge or ER physician's charge or ER physician's charge or initial office visit<br>• Regular benefits for x-ray, lab, pathology, and machine diagnostic test | PPO: In physician's office $10 copay. Outside physicain's office $50 copay per occurrence. | 40 |
| | Non-PPO: $50 copay per occurrence and the difference between our allowance and the billed amount (No Deductible) | |
| | Out-of-network: Only the difference between our allowance and the billed amount (No Deductible) | |
| • **Medical emergency** | Regular benefits | 41 |
| **Mental health and substance abuse treatment:** | PPO: Regular cost sharing. | 42 |
| | Non-PPO: Benefits are limited | 43 |
| | Out-of-network: Regular cost sharing | 43 |
| **Prescription drugs:** | | 47 |

| | | |
|---|---|---|
| | **Network Retail:** Tier 1: $5 (No Deductible), Tier 2: $30 (No Deductible),Tier 3: 30% or $45, whichever is greater (No Deductible)<br><br>**Network Mail Order:** Tier 1: $10 (No Deductible), Tier 2: $60 (No Deductible), Tier 3: 30% or $90, whichever is greater (No Deductible)<br><br>**Network Retail when Medicare Part B is primary:** Tier 1: $3 (No Deductible),Tier 2: $18 (No Deductible), Tier 3: 30% or $35, whichever is greater (No Deductible)<br><br>**Network Mail Order when Medicare Part B is primary:** Tier 1**:** $6 (No Deductible), Tier 2: $36 (No Deductible), Tier 3: 30% or $45, whichever is greater (No Deductible)<br><br>**Note: If there is no generic equivalent available, you will still have to pay the Tier 2 copay.**<br><br>**Specialty Medications must be received through one of our Specialty Pharmacy Providers to receive the retail benefit. There is no benefit if other providers are used.** | |
| **Dental care:** | Routine exams and fillings; fee schedule | 50 |
| **Special features:** | Center of excellence | 51 |
| | Medical Management Program | 51 |
| | Flexible benefits option | 51 |
| | Glucose monitors | 51 |
| | Healthy Maternity Program | 51 |
| | Lifestyle prescription medications | 51 |
| | Services overseas | 52 |
| | The Lab Card Program | 52 |
| **Protection against catastrophic costs (out-of-pocket maximum):** | PPO: Nothing after $3,500/Self Only or Family enrollment per year Non-PPO: Nothing after $7,000/Self Only or Family enrollment per year Out-of-network: Nothing after $3,000/ Self Only or Family enrollment per year Some costs do not count toward this protection | 15 |

# Notes

# 2009 Rate Information for Association Benefit Plan

**FEHB benefits of this Plan are described in the Association Benefit Plan Brochure**

| Type of Enrollment | Enrollment Code | Non-Postal Premium | | | |
|---|---|---|---|---|---|
| | | Biweekly | | Monthly | |
| | | Gov't Share | Your Share | Gov't Share | Your Share |
| **High Option Self Only** | 421 | $155.66 | $56.64 | $337.26 | $122.72 |
| **High Option Self and Family** | 422 | $352.56 | $136.49 | $763.88 | $295.73 |