Blue Preferred® Plus POS

http://www.anthem.com
Customer Service (888) 811-2092

2015

A Health Maintenance Organization with Point-of-Service

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details.

Serving: **St. Louis, Central, and Southwest areas in Missouri and St. Clair and Madison counties in Illinois**

Enrollment in this Plan is limited. You must live in our geographic service area to enroll. See page 14 for requirements.

IMPORTANT
- Rates: Back Cover
- Changes for 2015: Page 16
- Summary of benefits: Page 92

Enrollment codes for this Plan:

9G1	**Self Only**
9G2	**Self and Family**

Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-516

Important Notice from Blue Preferred Plus POS About

Our Prescription Drug Coverage and Medicare

OPM has determined that the Blue Preferred Plus POS 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. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug 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 cancel 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 Medicare Part D 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 will 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 (October 15 through December 7) 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 (800) 772-1213 (TTY: (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 (800) MEDICARE ((800) 633-4227), (TTY: (877) 486-2048)

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Introduction

This brochure describes the benefits of Blue Preferred Plus POS under our contract (CS 2838) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at (888) 811-2092 or through our website: www.anthem.com. This Plan is underwritten by HMO Missouri, Inc., dba Anthem Blue Cross and Blue Shield*. The address for the Blue Preferred Plus POS administrative office is:

Blue Preferred Plus POS, Mail No. OH0402-B014
1351 William Howard Taft Road
Cincinnati, OH 45206-1775

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

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, 2015, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each Plan annually. Benefit changes are effective January 1, 2015, and changes are summarized on page 16. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

*In Missouri, (excluding 30 counties in the Kansas City area) Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means Blue Preferred Plus POS.
- 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.
- Our brochure and other FEHB Plans' brochures have the same format and similar descriptions to help you compare Plans.

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 that 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 providers, 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.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- 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 (888) 451-1155 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

(877) 499-7295

OR go to www.opm.gov/oig

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- 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)
  - Your child age 26 or over (unless he/she is disabled and incapable of self-support prior to age 26)
- 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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

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 and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- 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 your pharmacist about the medication 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 or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. 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.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you use Blue Preferred Plus POS preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

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.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the ACA individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

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

  See www.opm.gov/healthcare-insurance 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 that 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 Benefits,* 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
  - 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. For information on your premium deductions, you must also contact 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 dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 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 of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26.

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.

If you have a qualifying life event (QLE) – such as marriage, divorce, or the birth of a child – outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren (including children of same-sex domestic partners in certain states) are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

- **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 2015 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 2014 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.

  If your enrollment continues after you are no longer eligible for coverage, (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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 continuance 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 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 website, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

You may not elect TCC if you are fired from your Federal or Tribal 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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHBP coverage.

- **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 or Tribal 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.

- **Health Insurance Marketplace** If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U. S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

General features of our HMO

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the Plan's benefits, not because a particular provider is available. You cannot change Plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

Who provides my health care?

This Plan is an individual-practice Plan. All participating doctors practice in their own offices in the community. Benefits are available from doctors, hospitals and other health care providers that are within the Blue Preferred Plus POS network or from non-network providers. The Plan arranges with doctors and hospitals to provide medical care for both the prevention of disease and the treatment of serious illness.

You may self-refer within the Blue Preferred Plus POS network. A wide variety of specialists and primary care physicians are available for you to choose from. Many are Board certified as indicated in the Blue Preferred Plus POS directory. If you need hospital care, your network doctor will admit you to a participating hospital where he/she has admitting privileges and ensure that the necessary preauthorizations and precertifications are in place. When you receive care from non-network providers, you are ultimately responsible for making sure that we have been contacted for any necessary preauthorization or precertification of care. You may also be responsible for charges that exceed the Plan's maximum allowable amount for covered non-network services.

Open access to network providers

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

We have Point of Service (POS) benefits

When you enroll in this Plan, you have access to Point-of-Service (POS) benefits. This means you can receive covered services from a non-participating provider (non-network). However, your out-of-pocket expenses for covered non-network services will be higher than your out-of-pocket expenses if you remain within the Blue Preferred Plus POS network. Under the POS benefits for non-network services, you must satisfy an annual deductible of $500 under Self only coverage and $1,500 under Self and Family coverage. After satisfying the deductible, you will be responsible for 30% coinsurance for covered services and all charges that exceed our payment, including charges for non-covered services. When your out-of-pocket expenses (deductible and 30% coinsurance) reach $5,000 under Self only coverage and $10,000 under Self and Family coverage, we will eliminate the coinsurance that you pay for covered non-network services but you will still be responsible for all charges that exceed our payment. Some services are not covered under the POS benefits. Please refer to Section 5 (i) Point of Service benefits for more information.

How we pay providers

We contract with individual physicians, medical groups, hospitals and other types of providers to provide the benefits in this brochure. These network providers accept a negotiated payment from us, and you will only be responsible for your copayments when you remain within our provider network.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

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. OPM's FEHB website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Disenrollment rates
- Compliance with State and Federal licensing or certification requirements
- Accreditations by recognized accrediting agencies and the dates received
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records
- Years in existence
- Profit status
- Transitional Care
- Medical Records

If you want more information about us, call (888) 811-2092, or write to Mail No. OH0402-B014, 1351 William Howard Taft Road, Cincinnati, Ohio 45206-1775. You will find important information about your member rights and responsibilities, and how we evaluate new technology for covered services at www.anthem.com. Go to Customer Support, then go to FAQs. You may also contact us by fax at (513) 872-3929.

Your medical and claims records are confidential

We have a Confidentiality Policy. This policy sets forth guidelines regarding a member's right to access and amend information in the Plan's possession. The Policy specifically addresses when a release, signed by a member, is required before information may be disclosed by the Plan to parties such as a member's provider, spouse, or other family members. Through the contract under which the Plan is administering your benefits, the Plan is not required to obtain your consent to the release of any information or records concerning claims for routine uses as may be reasonably necessary for the administration of your benefits. Please refer to our website www.anthem.com, *Frequently Asked Questions*, for further details.

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.

Service Area

To enroll in this Plan, you must live in our service area. This is where our providers practice. Our service area is:

The St. Louis Area, including the Missouri counties of Crawford, Franklin, Gasconade, Jefferson, Lincoln, Montgomery, Pike, St. Charles, St. Francois, St. Louis (City and County), Ste. Genevieve, Warren and Washington; *the Central Missouri Area* counties of Audrain, Boone, Callaway, Camden, Chariton, Cole, Cooper, Howard, Macon, Maries, Miller, Moniteau, Monroe, Morgan, Osage, Phelps, Pulaski, and Randolph; *the Southwest Missouri Area* counties of Barry, Barton, Cedar, Christian, Dade, Dallas, Douglas, Greene, Hickory, Jasper, Laclede, Lawrence, McDonald, Newton, Ozark, Polk, Stone, Taney, Texas, Webster and Wright.

You may also enroll with us if you live in the Illinois counties of Madison or St. Clair.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits.

If you or a covered family member move outside our service area, you can enroll in another Plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service Plan or an HMO that has agreements with affiliates in other areas or refer to Section 5(h) *Special Features* on page 62 for details regarding our reciprocity benefits. If you or a family member move, you do not have to wait until Open Season to change Plans. Contact your employing or retirement office. As a Blue Preferred Plus POS member, you may have access to physician care through the BlueCard® Traditional network for emergency or urgent care services. Benefits are easy to use – a "suitcase" logo on members' ID cards will identify them as BlueCard members. To locate a BlueCard provider outside the Blue Preferred Plus POS service area, you or a covered family member simply calls the toll-free BlueCard Access number on their ID card ((800) 810-BLUE (2583)) or visit the **BlueCard Hospital and Doctor Finder at www.anthem.com.** If there is no BlueCard provider near you, you should contact your Plan physician just as you would if you were at home. The Plan physician will provide a non-network referral and coordinate care with the out-of-area provider as appropriate.

Section 2. Changes for 2015

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

Changes to this Plan

- Your share of the non-Postal premium will increase for Self and Self and Family. See page 94.
- Currently network PCP visits are covered with a $25 per visit copayment. Now network PCP visits will have a $20 per visit copayment. (See Section 5(a))
- Currently network specialist visits are covered with a $35 copayment. Now network specialist visits will have a $40 copayment. (See Section 5(a))
- Currently there is no benefit for retail health clinic visits. Now retail health clinic visits will have a $20 network copayment and 30% coinsurance and any difference between our payment and the billed charge after meeting the annual deductible for non-network visits. (See Section 5(a))
- Currently professional services in an urgent care center are covered with a $0 copayment. Now professional services in an urgent care center are covered with a $40 copayment. (See Section 5(a))
- Currently emergency care in an urgent care center is covered with a $50 copayment. Now emergency care in an urgent care center is covered with a $40 copayment. (See Section 5(d))
- Currently there is no benefit for nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa. Now Mental health and substance abuse benefits will include coverage for nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa. (See Section 5(e))
- Currently Educational classes and programs only covered services for Tobacco cessation programs, Diabetes and Applied Behavior Analysis. Now Educational classes and programs will include coverage for nutritional counseling for the treatment of morbid obesity. (See Section 5(a))
- Currently the Network Catastrophic protection out-of-pocket limit is $3,000 for Self only or $6,000 for Self and Family enrollment. Now the Network out-of-pocket limit will be $3,500 for Self only or $7,000 for Self and Family enrollment. The Network Catastrophic protection out-of-pocket limit will now include Prescription Drug charges. (See Section 4)
- Currently the Non-network Catastrophic protection out-of-pocket limit is $4,500 for Self only or $9,000 for Self and Family enrollment. Now the Non-network out-of-pocket limit will be $5,000 for Self only or $10,000 for Self and Family enrollment. (See Section 4)
- Currently residential treatment centers were included in the Outpatient hospital or other covered facility benefits. Now residential treatment centers will be included in the Inpatient hospital or other covered facility benefits. (See Section 5 (e))
- Currently the network Physical therapy copayment is $25 per office visit to your PCP or $35 per office visit to a Specialist or outpatient facility. Now network Physical therapy visits will have a $20 copayment. (See Section 5(a))
- Currently benefits for Allogeneic and Non- myeloablative allogeneic transplants do not include coverage for Multiple myeloma. Now Multiple myeloma transplants (after a previous autologous stem cell transplant or due to primary graft failure, failure to engraft or rejection) will be covered under Allogeneic and Non- myeloablative allogeneic transplants. (See Section 5(b))

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form SF 2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (888) 811-2092. You may also request replacement cards through our website at www.anthem.com.

Where you get covered care

When you get care from "Plan providers" and "Plan facilities" you will only pay copayments and you will not have to file claims. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network. You may also obtain services from non-network providers, however, you will be responsible for higher out-of-pocket costs and may have to file claims.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs

- **Plan providers**

Plan providers are primary care physicians, specialists and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update annually. The Blue Preferred Plus POS directory is also on our website, www.anthem.com. The online directory is updated daily.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update annually. The list is also on our website.

What you must do to get covered care

How to Access Primary and Specialty Care Services

Your health plan covers care provided by primary care physicians and specialty care providers. To see a primary care physician, simply visit any network physician who is a general or family practitioner, internist or pediatrician. Your health plan also covers care provided by any network specialty care provider you choose. Referrals are not needed to visit any network specialty care provider, including behavioral health. However, there are certain services that may require prior approval by us; see Section 3, pages 20-21. Please note that Emergency and Urgent care services do not require prior approval from us.

To make an appointment call your physician's office:

- Tell them you are an < health plan > member.
- Have your Member ID card handy. They may ask you for your group number, member I.D. number, or office visit copay.
- Tell them the reason for your visit

When you go for your appointment, bring your Member ID card.

- **Primary care**

Selecting a Primary Care Physician (PCP) is important. A PCP can be a family practitioner, internist, or pediatrician. Your PCP will provide most of your health care.

- **Specialty care**

Here are some things you should know about specialty care:

You do not need a referral from your primary care physician. You may self-refer within the network for medically necessary care.

If you have a chronic and disabling condition and lose access to your specialist because we:

- terminate our contract with your specialist for other than cause;
- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
- reduce our Service Area and you enroll in another FEHB plan;

you may be able to continue seeing your specialist 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 until the end of your postpartum care, even if it is beyond the 90 days.

Inpatient, residential treatment and certain outpatient treatment for mental health and substance abuse require precertification. When you remain within our network, the provider is responsible for contacting us to obtain precertification. However, when you seek non-network care, you are ultimately responsible for contacting us to obtain precertification.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **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 (888) 811-2092. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on 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;
- 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 Program 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.

You need prior Plan approval for certain services

What is Utilization Management?
We use a process called Utilization Management (UM). This process helps us:

- Decide if certain outpatient care, inpatient hospital care or procedures are medically necessary for our members.
- Decide if the services will be covered by our members' health plans.
- Make sure you're getting the right care at the right time.

How it works
Our UM review team, made up of licensed health care professionals such as nurses and doctors, do medical reviews. The review team:

- Goes over the information your doctor sent us to see if the requested surgery, treatment or other type of care is medically needed.
- Checks to make sure the treatment meets the terms, benefits, limitations and exclusions set by your health plan.
- Researches if you can see a provider outside of the network if one is not available within the network.
- After reviewing the records and information, the team will approve (cover) or deny (not cover) the treatment.
- Lets you and your doctor know as soon as possible.

Types of reviews
The UM review team performs these types of reviews before, during and after a member's treatment:

- **The prospective or preservice review (done before you get medical care)** – We may do a prospective review before you go to the hospital or get other types of service or treatment. Here are medical needs that might call for a prospective review:
  - A hospital visit
  - An outpatient procedure
  - Tests to find the cause of an illness, such as MRI or CT scans
  - Certain types of outpatient therapy, such as physical therapy or emotional health counseling
  - Durable medical equipment (DME), such as wheelchairs, walkers, crutches or hospital beds
- **The concurrent review (done during medical care and recovery)** – We do a concurrent review when you are in the hospital or are released and need more care related to the hospital stay. The UM review team looks at your medical information at the time of the review to see if the treatment is medically needed. These reviews could include:
  - Services or treatment in a doctor's office
  - Regular office visits

- Physical or emotional therapy
- Home health care, durable medical equipment (DME)
- A stay in a nursing home
- Emotional health care visits

- **The retrospective or post-service review (done after you get medical care)** – We do a retrospective review when you have already had surgery or another type of medical care. This is when the UM review team learns about the treatment, then looks at the medical information the doctor or provider had about you at the time the medical care was given. The team can see if the treatment was medically needed.

What does pre-authorization mean?
Pre-authorization is the process of getting approval from your health plan before you get services. Think of it like a pre-approval to make sure we will cover a service, supply, therapy or drug.

We approve services that meet our standards for needed and appropriate treatment:

- The guidelines we use to approve treatment are based on standards of care in medical policies, clinical guidelines and the terms of your plan.
- As these may change, we review our pre-authorization guidelines regularly.
- Pre-authorization is also called "precertification," "prior authorization," or "pre-approval."

Why getting pre-authorization helps you
Finding out ahead of time that your service is approved:

- **Saves you time**. Pre-authorizing services saves you a step because you will know if you are eligible and what your benefits cover before you get the service. The doctors in our network ask for pre-authorization for our members.
- **Saves you money**. Paying only for medically necessary services helps everyone save. Choosing a doctor in our network can help you save even more. See Stretch your health care dollar.

If you choose an out-of-network provider, be sure to call us to see if you need pre-authorization. Providers who are not in the network may not do that for you. If you ever have a question about whether you need pre-authorization, just call the pre-authorization or precertification phone number on your member ID card.

Since your network primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your network primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. If you seek covered care from non-network providers, you are ultimately responsible for contacting us to obtain our prior approval before proceeding with the service(s). **We call this review and approval process precertification.** The following list includes, but is not limited to, services that require precertification:

- All inpatient admissions (except maternity)
- Newborn stays beyond the discharge of the mother

- Transplants (Human Organ and Bone Marrow/Stem Cell)
- Lumbar spinal fusion surgeries
- Uvulopalatopharyngoplasty, uvulopharyngoplasty surgery (UPPP)
- Plastic/Reconstructive surgeries such as but not limited to: Blepharoplasty, Rhinoplasty, and Panniculectomy and Lipectomy/diatasis Recti Repair
- Durable Medical Equipment (DME) – specialized or motorized/powered wheelchairs and accessories, hospital beds, rocking beds and air beds
- Prosthetics – electronically or externally powered and custom made and/or custom fitted prefabricated orthotics and braces
- Surgical treatment of morbid obesity
- Private duty nursing in a home setting
- Certain prescription drugs, such as Growth Hormones
- Diagnostic imaging such as, but not limited to: Computed Tomography (CT), Computed Tomographic Angiography (CTA), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Magnetic Resonance Spectroscopy (MRS), Nuclear Cardiology and Positron Emission Tomography (PET)
- Mental health/Substance abuse services such as but not limited to: Inpatient admissions, intensive outpatient therapy, partial hospitalization, residential care and Electric Convulsive Therapy (ECT)

Precertification is a feature that requires an approval be obtained from us before incurring expenses for certain covered services. When care is evaluated, both medical necessity and appropriate length of stay will be determined. Medical necessity includes a review of both the services and the setting. For certain services you will be required to use the provider designated by Our Health Care Management staff. The care will be covered according to your benefits for the number of days approved unless our concurrent review determines that the number of days should be revised. If a request is denied, the provider may request a reconsideration. An expedited reconsideration may be requested when your health requires an earlier decision.

For emergency admissions, precertification is not required. However, you must notify us of your admission within 24 hours or as soon as possible within a reasonable period of time.

Predetermination is the process of requesting approval of benefits before the service or supply is rendered.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at (800) 992-5498 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay

- **Non-urgent care claims**

  For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

  If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

  If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

  If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) to end of the time frame, whichever is earlier.

  We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

  You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at (888) 811-2092. You may also call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at (888) 811-2092. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

  A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

  If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

• **Emergency inpatient 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 physician, 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.
• **Maternity care**	For childbirth admissions, precertification is not required. If there is a complication and/or the mother and baby are not discharged at the same time, precertification for an extended stay or for additional services is required.
• **If your treatment needs to be extended**	If you need an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.
What happens when you do not follow the precertification rules when using non-network facilities	Since precertification is part of the prior approval process you would need approval to use a non-network facility. If you use a non-network facility without prior approval or precertification you may be financially responsible for the charges. You should always make sure that we have been contacted to perform precertification for non-network services.
Circumstances beyond our control	Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.
If you disagree with our pre-service claim decision	If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.
• **To reconsider a non-urgent care claim**	Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure. In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to 1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or 2. Ask you or your provider for more information. 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. 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. We will write to you with our decision. 3. Write to you and maintain our denial.
• **To reconsider an urgent care claim**	In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure. Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM** — After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

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 (i.e., 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 covered services from within our provider network. Example: • When you see your network primary care physician you pay a copayment of $20 per office visit.
Deductible	A deductible is a fixed expense you must incur for covered services and supplies under the POS benefits before we start paying benefits. The deductible is $500 for Self only coverage and $1,500 for Self and Family coverage. We do not apply a deductible to covered care that you receive within the HMO network.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible. Example: • Under the POS benefits, you pay 30% of our allowance for covered non-network services.
Differences between our Plan allowance and the bill	When you receive covered services from non-network providers you are responsible for the difference between the actual charge and the Plan's maximum allowable amount. See Section 5(i) Point of Service benefits for more details.
Your catastrophic protection out-of-pocket maximum	**Network Services** After your network copayments and coinsurance total $3,500 for Self only or $7,000 for Self and Family enrollment for medical services in any calendar year, you do not have to pay any more for covered services. **Non-network Services (POS)** After your deductible and coinsurance for POS benefits totals $5,000 for Self only or $10,000 for Self and Family enrollment for covered non-network services, you do not have to pay any further deductible and/or coinsurance for covered services. However, you are responsible for the difference between the actual charge and the Plan's maximum allowable amount. Be sure to keep accurate records of your copayments and/or coinsurance since you are responsible for informing us when you reach the maximum.
Erroneous benefit payments	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. ***Note:*** We will generally first seek recovery from the provider if we paid the provider directly, or from the person (covered family member, guardian, custodial parent, etc.) to whom we sent our payment.

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 your 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.
When Government facilities bill us	Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services 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. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

See page 16 for how our benefits changed this year. Pages 92 and 93 contain a benefits summary. Make sure that you review the benefits that are available to you.

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Section 5. Benefits Overview

The benefit package is described in Section 5. Make sure that you carefully review the benefits that are available.

Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at (888) 811-2092 or on our website at www.anthem.com.

When you seek care from within our network, we offer the following unique features:

- No referrals needed for care from network providers
- No deductibles
- No office visit copay for covered preventive care services
- $20 primary care office visit copay for non-preventive care
- $40 specialty care office visit copay
- $500 copay per covered inpatient hospital admission
- $200 outpatient facility copay for surgery
- $150 emergency room copay

When you seek care from non-network providers, we offer the following POS features:

- Freedom of choice when accessing covered care from non-network providers
- After the annual deductible of $500 Self only or $1,500 Self and Family, you pay 30% coinsurance for covered services
- When your out-of-pocket expenses for covered POS services adds up to $5,000 Self only and $10,000 Self and Family, we eliminate the 30% coinsurance

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.
- In order for network benefits to apply, Plan physicians must provide or arrange your care within the network.
- We do not apply a calendar year deductible to covered network services.
- Please see Section 5(i) for information regarding POS benefits for Non-Network services. We will apply an annual deductible ($500 Self only or $1,500 Self and Family) and 30% coinsurance to covered POS services. You are also responsible for all charges that exceed our payment. Under POS, the annual catastrophic protection out-of-pocket maximum is $5,000 for Self only and $10,000 for Self and Family.
- A network facility copay or POS coinsurance will apply to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Under the POS benefits, you are ultimately responsible for ensuring that your Non-Network provider obtains our prior-approval and/or precertification for certain services.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• Online clinic visit • Retail Health clinic	Network: $20 PCP office visit POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Professional services of physicians • During a hospital stay • In a skilled nursing facility	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• In an urgent care center	$40 per visit
At home	Network: $20 per visit by your PCP or $40 per visit by a Specialist POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge

Diagnostic and treatment services - continued on next page

Benefit Description	You pay
Diagnostic and treatment services (cont.)	**High Option**
Not covered: • *Care that is not medically necessary* • *Care that is investigational*	*All charges*
Lab, X-ray and other diagnostic tests	**High Option**
Laboratory tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound/Sonogram – one routine ultrasound/sonogram for a normal pregnancy • Electrocardiogram and EEG	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• CT Scans, MRI, MRA, PET, nuclear cardiology imaging studies and non-maternity related ultrasounds Note: MRI's, MRA's, PET, all CT's (including CTA), Nuclear Cardiology, and MRS will require prior approval (see page 21).	Network: $150 per test POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Preventive care, adult	**High Option**
Periodic preventive examinations and routine screenings, such as: • Total blood cholesterol - once every three years* • Colorectal cancer screening, including - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 And other diagnostic tests as recommended by the American Cancer Society Guidelines • Chlamydia Screening • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older* • Routine Pap test – annual* • Osteoporosis screening • Abdominal Aortic Aneurysm screening – ultrasonography, one between the age of 65 and 75, for men with a history of smoking. • Screening for obesity and referrals for behavior change interventions for adults with a Body Mass Index (BMI) over 30kg/m2 ***Or more frequently if recommended by your Blue Preferred Plus POS physician***	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
Well woman care; including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing
• Routine mammogram – once per calendar year or more frequently if recommended by a physician	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. Additional resources available at: HHS: www.healthcare.gov/prevention, IOM: http://www.iom.edu/Reports/2011/Early-Childhood-Obesity-Prevention-Policies/Recommendations.aspx AAP: http://www2.aap.org/immunization/pediatricians/pediatricians.html, CDC: http://www.cdc.gov/nccdphp/dnpao/hwi/resources/preventative_screening.htm.	
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*	*All charges*
Preventive care, children	**High Option**
Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction - Newborn hearing screening, rescreening and initial amplification - Examinations done on the day of immunizations (up to age 22) • Childhood immunizations recommended by the American Academy of Pediatrics	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**High Option**
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. Additional resources available at: HHS: www.healthcare.gov/prevention, IOM: http://www.iom.edu/Reports/2011/Early-Childhood-Obesity-Prevention-Policies/Recommendations.aspx AAP: http://www2.aap.org/immunization/pediatricians/pediatricians.html, CDC: http://www.cdc.gov/nccdphp/dnpao/hwi/resources/preventative_screening.htm.	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*	*All charges*
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care – includes one routine ultrasound/sonogram for a normal pregnancy • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 20 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. If you leave in less than 48 hours (or 96 hours after a cesarean delivery), we will cover two home visits by a registered nurse provided through a network home health agency. • 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 only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	Network: $20 per office visit (office visit copay applies to the initial visit only for routine obstetrical care) POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge Note: You owe an inpatient hospital admission copay for network hospital services. The annual deductible and 30% coinsurance applies to non-network facilities under the POS benefits. See Section 5(c) *Services provided by a hospital or other facility, and ambulance services.*
Breastfeeding support, supplies and counseling for each birth	Nothing
Family planning	**High Option**
Contraceptive counseling	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling* • *Voluntary abortions and related care*	*All charges*

Family planning - continued on next page

Benefit Description	You pay
Family planning (cont.)	**High Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5(b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist and nothing for family planning services POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Infertility services	**High Option**
• Services limited to: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist and nothing for infertility services POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• Fertility drugs Note: We cover fertility drugs under the prescription drug benefit. Please refer to Section 5(f). Preauthorization is required for fertility medication.	Applicable prescription drug copays
Not covered: • *Treatment for infertility following voluntary sterilization (unless due to chemotherapy or radiation treatment)* • *Costs associated with cryo-preservation and storage of sperm, eggs and Embryos; provided however, subsequent procedures of a medical nature necessary to make use of the cryo-preserved substance will not be similarly excluded if deemed non-experimental and non-investigational* • *Non-medical costs of an egg or sperm Donor* • *Infertility treatments rendered to dependents under the age of 18* • *Any treatment not specified as covered*	*All charges*
Allergy care	**High Option**
• Testing and treatment	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• Allergy injections	Network: $3 per visit Note: The $20 PCP office visit or $40 Specialist office visit copay applies if other services are rendered during your visit to a network provider.

Allergy care - continued on next page

Benefit Description	You pay
Allergy care (cont.)	**High Option**
	POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• Allergy serum	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on pages 45-48.	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist and nothing for chemotherapy and radiation therapy POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis	Network: $20 per PCP visit or $40 per Specialist or outpatient visit POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	Network: $20 per PCP visit or $40 per Specialist visit and nothing for intravenous (IV)/infusion therapy services POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit.	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist and the applicable prescription drug copay for Growth Hormones

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	**High Option**
Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on pages 20-21. Approval is based on our medical policy. We may ask you or your physician to submit, through our predetermination process, the following: - A letter of medical necessity - Laboratory results, and - A growth chart	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist and the applicable prescription drug copay for Growth Hormones POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Therapy that is not listed as covered in this booklet. For example, massage therapy or exercise conditioning.*	*All charges*
Physical, occupational and speech therapies	**High Option**
• Up to a combined maximum of 60 visits per calendar year for rehabilitative and habilitative physical, occupational and speech therapy. For the services of each of the following: - Occupational therapists - Speech therapists Note: We only cover therapy when a provider: - orders the care	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist or outpatient facility POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
- Qualified physical therapists Note: We only cover therapy when a provider: - orders the care	Network: $20 per physical therapy visit POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• Cardiac rehabilitation following, but not limited to, a heart transplant, bypass surgery or a myocardial infarction, is provided for one consecutive 12-week program per calendar year. • Pulmonary rehabilitation for up to 14 sessions within 12 months and then one session every 3 months thereafter.	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist or outpatient facility POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs.*	*All charges*

Benefit Description	You pay
Hearing services (testing, treatment, and supplies)	**High Option**
• Routine hearing exams • Newborn hearing, screening, rescreening and initial amplification	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• One routine eye exam with refraction per year Note: See *Preventive care, children* for eye exams for children.	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• First pair of prescribed contact or eyeglass lenses following cataract surgery Note: Contact lenses or glasses are often prescribed following intraocular lens implantation for the treatment of cataracts. See *Orthopedic and prosthetic devices* for internal device insertion benefits.	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist and nothing for first pair of lenses POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Eyeglasses (frames and lenses)* • *Contact lenses, contact fittings or contact examinations* • *Eye exercises and vision training* • *Radial keratotomy and other refractive surgery* • *Photo-Refractive keratectomy (PRK)*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above*	*All charges*

Foot care - continued on next page

Benefit Description	You pay
Foot care (cont.)	**High Option**
• *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Sacral nerve stimulators when medically necessary to treat urge incontinence, urge frequency or urinary retention without mechanical obstruction. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5 (c) Services provided by a hospital or other facility, and ambulance services.	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist and 20% coinsurance for orthopedic and prosthetic devices POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• One wig, when necessitated by hair loss due to covered radiation therapy or chemotherapy.	Network: Nothing up to a $175 maximum allowance POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Orthopedic shoes (except therapeutic shoes for diabetes)* • *Heel pads and heel cups* • *Foot support devices, such as arch supports and corrective shoes unless they are an integral part of a leg brace* • *Orthotic devices used primarily for convenience, comfort or for participation in athletics*	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include but are not limited to: • Oxygen • Hospital beds • Wheelchairs • Crutches, walkers	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist and 20% coinsurance for durable medical equipment (DME) POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**High Option**
• Blood glucose monitors (when purchased at a participating medical supply provider) • Insulin pumps • First pair of lenses following cataract removal • Hemodialysis and dialysis equipment • Traction and suspension equipment • Sleep apnea, cardiac and neonatal (high risk infant) monitors • Medical supplies, such as surgical dressings and colostomy bags and casting supplies • Manual breast pumps • Automatic blood pressure monitors • Compression (anti-embolic) stockings (up to 2 pairs per calendar year) Note: Rental cost must not be more than purchase price Note: Durable medical equipment is equipment which can withstand repeated use; primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home.	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist and 20% coinsurance for durable medical equipment (DME) POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge Note: You are responsible for any charges that exceed our allowance for basic equipment.
Not covered: • *Devices and equipment used for environmental control or to enhance the environmental setting, such as air conditioners, humidifiers or air filters* • *Supplies that can be used by other family members such as: adhesive tape, band-aids, alcohol and cotton balls* • *Raised toilet seats* • *Personal hygiene and convenience items* • *Mechanical beds, such as Craftmatic Adjustable Beds* • *Mattresses, sheets, pads, pillows, rubber sheets* • *Therabath, hot tubs, Jacuzzis, saunas, portable whirlpool pumps* • *Chair lifts and tub chairs* • *Exercise equipment, including but not limited to exercise bikes and treadmills* • *Ice bags and/or cold pack pump therapy* • *Corsets or other articles of clothing* • *Food or food supplements*	*All charges* *Any charges above the allowed amount for the basic equipment.*

Benefit Description	You pay
Home health services	**High Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Your physician will periodically review the program for appropriateness and need. • Services include oxygen therapy, intravenous therapy and medications.	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*
Chiropractic	**High Option**
• 26 visits per calendar year. • Manipulation of the spine and extremities. • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application.	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist Note: This benefit is covered within the network only. We do not provide POS benefits for chiropractic services
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Maintenance care* • *Relaxation therapy* • *Out-of-network services*	*All charges*
Alternative treatments	**High Option**
No benefit. See Non-FEHB page.	*All charges*
Educational classes and programs	**High Option**
• Tobacco cessation program includes: - individual, group, and telephone counseling - coverage for physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Note: See Section 5(f) Prescription benefits for information on physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence. See Section 5(e) for information on individual and group psychotherapy.	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
• Diabetes Note: Please refer to Section 5(h) Special Features for information on our disease management programs for asthma and diabetes.	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist and nothing if received in a non-office setting. POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• Applied Behavior Analysis (ABA) for dependent children through age 18.	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Nutritional counseling for the treatment of obesity	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Any educational service not listed above as covered*	*All charges*
Cancer clinical trials	**High Option**
Routine patient costs for individual participation in phase I, II, III or IV clinical trials conducted to prevent, detect or treat cancer, life-threatening diseases or conditions that are Federally funded; conducted under investigational new drug application reviewed by FDA; or conducted as a drug trial exempt from the requirement of an investigational new drug application.	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist and nothing for the routine care associated with phase I, II, III or IV clinical trials for cancer treatment POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.* • *Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials.*	*All charges*

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.
- In order for network benefits to apply, Plan physicians must provide or arrange your care within the network.
- We do not apply a calendar year deductible to covered network services.
- Please see Section 5(i) for information regarding POS benefits for Non-Network services. We will apply an annual deductible ($500 Self only or $1,500 Self and Family) and 30% coinsurance to covered POS services. You are also responsible for all charges that exceed our payment. Under POS, the annual catastrophic protection out-of-pocket maximum is $5,000 for Self only and $10,000 for Self and Family.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR NETWORK PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification. Under the POS benefits, you are ultimately responsible for ensuring that your non-network physician obtains our prior approval and/or requests precertification.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Network: Nothing, unless performed during an office visit, then $20 per office visit to your PCP or $40 per office visit to a Specialist POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
• Surgical treatment of morbid obesity (bariatric surgery) – eligible members must be age 18 or over and weigh 100 pounds or 100% over his or her normal weight according to current underwriting standards and meet the following criteria: - BMI of 40 or greater, or BMI of 35 or greater with co-morbid conditions including, but not limited to, life threatening cardio-pulmonary problems (severe sleep apnea, Pickwickian syndrome and obesity related cardiomyopathy), diabetes mellitus, cardiovascular disease or hypertension; and - Must have actively participated in non-surgical methods of weight reduction (these efforts must be fully appraised by the network physician requesting authorization for surgery). The physician requesting preauthorization for the surgery must confirm the following as part of the evaluation process: - The patient's psychiatric profile is such that he or she is able to understand, tolerate and comply with all phases of care and is committed to long-term follow-up requirements; - The patient's post-operative expectations have been addressed; - The patient has undergone a preoperative medical consultation and is felt to be an acceptable surgical candidate; - The patient has undergone a preoperative mental health assessment and is felt to be an acceptable candidate; - The patient has received a thorough explanation of the risks, benefits, and uncertainties of the procedure; - The patient's treatment plan includes pre- and post-operative dietary evaluations and nutritional counseling; and - The patient's treatment plan includes counseling regarding exercise, psychological issues and the availability of supportive resources when needed.	Network: Nothing, unless performed during an office visit, then $20 per office visit to your PCP or $40 per office visit to a Specialist POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect. • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes.	Network: Nothing, unless performed during an office visit, then $20 per office visit to your PCP or $40 per office visit to a Specialist POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**High Option**
• All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) 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.	Network: Nothing, unless performed during an office visit, then $20 per office visit to your PCP or $40 per office visit to a Specialist POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *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.* • *Surgeries related to sex transformation or the reversal thereof.*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Extractions of teeth that interfere with radiation therapy; • Treatment of trauma resulting in injuries to the jaw, cheeks, lips, tongue, roof and floor of the mouth; • Treatment of bony impactions; • Surgical correction of anatomical abnormalities for treatment of temporomandibular (TMJ) disease when approved in advance by Blue Preferred Plus POS; • Other surgical procedures that do not involve the teeth or their supporting structures. Note: We will cover general anesthesia in conjunction with covered oral surgical procedures only for patients as indicated below: • Children through age 4; • Severely disabled people; and • People with medical or behavioral conditions that require hospitalization or general anesthesia for dental care. The general anesthesia must be provided in a network hospital, network freestanding surgery center or dentist's office. The dental procedures themselves are not covered.	Network: Nothing, unless performed during an office visit, then $20 per office visit to your PCP or $40 per office visit to a Specialist POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay
Oral and maxillofacial surgery (cont.)	**High Option**
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart-lung • Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs such as the liver, stomach, and pancreas • Lung - single/bilateral/lobar	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Tandem transplants for covered transplants: subject to medical necessity review by the Plan. Autologous tandem transplants: • AL Amyloidosis • Multiple myeloma (de novo and treated) • Recurrent germ cell tumors (including testicular cancer)	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Blood or Marrow Stem Cell Transplants: Not subject to medical necessity. Plan's denial is limited to the cytogenetics, subtype or staging of the diagnosis (e.g. acute, chronic) as appropriate for the diagnosis Allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) • Hemoglobinopathy	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic Syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia Autologous transplant for: • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma recurrence (relapsed) • Advanced non-Hodgkin's lymphoma recurrence (relapsed) • Amyloidosis • Neuroblastoma	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning for member over 60 years of age with a diagnosis listed under Section II): Subject to Medical Necessity.	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Blood or Marrow Stem Cell Transplants: Not subject to medical necessity: Allogeneic transplant for: • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) Autologous transplants for: • Multiple myeloma • Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May Be Limited to Clinical Trials. Autologous transplants for: • Advanced Ewing sarcoma • Advanced Childhood kidney cancers • Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) • Childhood rhabdomyosarcoma • Epithelial ovarian cancer • Mantle Cell (Non-Hodgkin lymphoma)	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
Blood or Marrow Stem Cell Transplants under clinical trials. Allogeneic transplants for: • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Sickle cell • Multiple myeloma (after a previous autologous stem cell transplant or due to primary graft failure, failure to engraft or rejection) • Beta Thalassemia Major Non-myeloablative allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Chronic lymphocytic lymphoma/small lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma (after a previous autologous stem cell transplant or due to primary graft failure, failure to engraft or rejection) • Myeloproliferative Disorders • Myeloproliferative/Myelodysplastic Syndromes • Sickle Cell disease	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Blood or Marrow Stem Cell Transplants Allogeneic transplants for: • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) • Myeloproliferative disorders • Sickle cell anemia • X-linked lymphoproliferative syndrome Autologous transplants for: • Ependymoblastoma • Ewing's sarcoma • Medulloblastoma • Pineoblastoma	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Waldenstrom's macroglobulinemia	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
National Transplant Program (NTP) – We are a member of the Blue Distinction Center for Transplant. All care for transplants must be coordinated through Blue Preferred Plus POS in writing. The physician should send a letter to the Blue Preferred Plus POS Medical Director requesting precertification. If you live outside the St. Louis metropolitan area, we may cover up to $10,000 in reasonable and necessary expenses for transportation, lodging and meals while you are away from home for the transplant. *This must be approved in advance by Case Management.*	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Donor testing for up to four bone marrow transplant donors from individuals unrelated to the patient in addition to testing of family members per year.	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Implants of artificial organs* • *Transplants not listed as covered* • *Donor screening tests and donor search expenses, except as shown above*	*All charges*
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center Note: We will cover general anesthesia in conjunction with covered oral surgical procedures only for patients as indicated below: • Children through age 4; • Severely disabled people; and • People with medical or behavioral conditions that require hospitalization or general anesthesia for dental care. The general anesthesia must be provided in a network hospital, network freestanding surgery center or dentist's office. The dental procedures themselves are not covered.	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge

Anesthesia - continued on next page

Benefit Description	You pay
Anesthesia (cont.)	**High Option**
• Office	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge

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 order for network benefits to apply, Plan physicians must arrange your care within the network.
- We do not apply a calendar year deductible to covered network services.
- Please see Section 5(i) for information regarding POS benefits for Non-Network services. We will apply an annual deductible ($500 Self only or $1,500 Self and Family) and 30% coinsurance to covered POS services. You are also responsible for all charges that exceed our payment. Under POS, the annual catastrophic protection out-of-pocket maximum is $5,000 for Self only and $10,000 for Self and Family.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.
- The amounts listed below are for the charges billed by the facility. Any costs associated with the professional services (i.e., physician, anesthesiologist, etc.) are in Sections 5(a) or (b).
- **YOUR NETWORK PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification. Under the POS benefits, you are ultimately responsible for ensuring that we have precertified or approved your hospital admission.

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Network: $500 per admission POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Custodial care*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
• *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care, except when medically necessary.*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Network: $200 Facility charge copay Note: This copay only applies when a surgical procedure is performed. POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• CT Scans, MRI, MRA, PET, nuclear cardiology imaging studies and non-maternity related ultrasounds Note: MRI's, MRA's, PET, all CT's (including CTA), Nuclear Cardiology, and MRS will require prior approval (see page 21).	Network: $150 per test POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Extended care/skilled nursing facility benefits - Up to 60 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically necessary as determined by a Plan doctor and approved by the Plan.	Network: $500 per admission POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Custodial care, domiciliary or convalescent care*	*All charges*
Hospice care	**High Option**
When a terminally ill member's life expectancy has reached six months or less, the member may benefit from hospice care. This care provides pain control and emotional support.	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	**High Option**
Your primary care physician must obtain advance approval from Blue Preferred Plus POS. You must go to a network hospital or receive care from a network home health agency licensed to provide hospice care. The hospice provider will write a treatment plan for your signature. Blue Preferred Plus POS and your primary care physician must coordinate your care. We also cover inpatient hospice care for short-term pain control.	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Independent nursing* • *Homemaker services*	*All charges*
Ambulance	**High Option**
Local professional ambulance service when medically appropriate	Nothing

Section 5(d). Emergency 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.
- POS does not apply to emergency benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.
- When you need emergency medical care outside of the U.S., go to the nearest hospital. Call the Placard Worldwide Service Center at (800) 810-BLUE (2583), or call collect at (804) 673-1177, if you are admitted.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies at network hospitals within our service area

If possible, when an unexpected condition arises, call your network physician – unless you believe any delay would be harmful. This applies even if it's after office hours. Your network physician will tell you whether to go to the emergency room.

If you need additional care after an emergency condition is stabilized, precertification is required. Your Blue Preferred Plus POS physician will handle this for you. We will make a decision about the care within 30 minutes after we receive all the necessary information.

When you need care right away but it is not an emergency, always call a network physician first. The network physician may have you come into the office for an urgent appointment. An urgent appointment is one scheduled with a network physician for the same day or during hours not normally used for appointments.

Emergencies at non-network hospitals (inside or outside our service area)

If possible, when an unexpected condition arises, call your network physician unless you believe any delay would be harmful. This applies even if it's after office hours. Your network physician will tell you whether to go to the emergency room.

If you need additional care after an emergency condition is stabilized, precertification is required. We will make a decision about the care with 30 minutes after we receive all the necessary information.

If you are admitted as an inpatient in a non-network hospital as a result of an emergency, you, your doctor or a family member should call Blue Preferred Plus POS as soon as possible for precertification of the case.

When you need care right away but it is not an emergency, always call your network physician. Your network physician may have you come into the office for an urgent appointment. An urgent appointment is one scheduled with a network physician for the same day or during hours not normally used for appointments.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Benefit Description	You pay
Emergency within our service area	**High Option**
• Emergency care at a doctor's office	$20 per primary care office visit $40 per specialty care office visit
• Emergency care at an urgent care center	$40 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services • Hospital observation Note: If you need follow-up care after emergency treatment, call your network physician. Note: We will only apply the emergency room copay as long as you are not admitted as inpatient to the hospital.	$150 per visit; if visit results in an inpatient admission, you pay $500
Not covered: • *Elective or non-emergency care*	*All charges*
Emergency outside our service area	**High Option**
• Emergency care at a doctor's office	$20 per primary care office visit $40 per specialty care office visit
• Emergency care at an urgent care center	$40 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services • Hospital observation Note: If you need follow-up care after emergency treatment, call your network physician. Note: We will only apply the emergency room copay as long as you are not admitted as inpatient to the hospital.	$150 per visit; if visit results in an inpatient admission, you pay $500
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*	*All charges*
Ambulance	**High Option**
Professional ambulance and air ambulance service when medically appropriate. Transportation by air ambulance must be approved in advance by Blue Preferred Plus POS. See Section 5(c) for non-emergency service.	Nothing

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

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 order for network benefits to apply, Plan physicians must provide or arrange your care within the network.
- Please see Section 5(i) for information regarding POS benefits for Non-Network services. We will apply an annual deductible ($500 Self only or $1,500 Self and Family) and 30% coinsurance to covered POS services. You are also responsible for all charges that exceed our payment. Under POS, the annual catastrophic protection out-of-pocket maximum is $5,000 for Self only and $10,000 for Self and Family.
- Pre-approval or precertification must be obtained if Non-Network providers are used. Also read Section 5(d) about emergency services.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.
- **CERTAIN SERVICES REQUIRE PREAUTHORIZATION.** Please refer to the precertification information shown in Section 3 to be sure which services require preauthorization. Under the POS benefits, you are ultimately responsible for ensuring that we have approved or precertified the services.

Benefit Description	You pay
Professional services	**High Option**
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist or diagnostic test POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• Inpatient hospital physician visit	Nothing
• Individual and group psychotherapy for the treatment of smoking cessation	Nothing

Professional services - continued on next page

Benefit Description	You pay
Professional services (cont.)	**High Option**
• Nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa.	Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Residential treatment centers	Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization program (PHP), half-way house, full-day hospitalization, or facility-based intensive outpatient treatment (IOP) - Partial Hospitalization Program (PHP) is a structured, short-term treatment modality that involves nursing care and active treatment provided by medical professionals and licensed mental health professionals. The program meets for a minimum of six hours per day, 5 days per week. - Intensive Outpatient Program (IOP) is a structured, short-term treatment modality that involves a combination of individual, group, and family therapy. Treatment is provided by licensed mental health professionals for a minimum of 3 hours per day, 3 times per week.	Network: $40 per outpatient visit POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Marital counseling*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 59.
- 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.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- We do not have a calendar year deductible for services you receive under the HMO benefits.
- POS does not apply to the prescription drug benefits as you must use network pharmacies to fill your medication.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy or by mail for a maintenance medication. Most maintenance drugs are available through mail order. To find out if a certain maintenance drug is available by mail order, call (800) 293-2202.
- **We use an incentive-based four-tier formulary**. Drugs are prescribed by Plan doctors and dispensed in accordance with Blue Preferred Plus POS's drug formulary. A formulary is a list of preferred drugs chosen for use based upon their effectiveness, safety and cost. We update our formulary throughout the year. To obtain our formulary, you may check the Anthem website at www.anthem.com or call Client Services at (888) 811-2092. The Plan may require authorization for certain drugs before they are dispensed. It is the prescribing doctor's responsibility to obtain the Plan's authorization. You pay a $5 copay per prescription unit or refill for Tier 1 drugs; $40 for Tier 2 drugs; $60 for Tier 3 drugs and 25% of Plan's allowance up to a maximum out-of-pocket of $150 per prescription order for a 30-day supply for Tier 4 drugs. When a Tier 1 drug is available but your physician requests the brand name drug, you pay the price difference between the Tier 1 drug and brand name drug as well as the $5 copay per prescription or refill unless your physician has obtained prior authorization for the brand name drug. When the physician has obtained the prior authorization, you pay only the appropriate brand copay.
- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply for retail or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin); and are available at $5 for Tier 1; $40 for Tier 2; and $60 for Tier 3. Tier 4 drugs will be 25% of Plan's allowance up to a maximum out-of-pocket of $150 per 30-day supply. Mail order prescription drugs are dispensed for up to a 90-day supply, and are available at $12.50 for Tier 1; $100 for Tier 2; and $150 for Tier 3. If a Member is called to active military duty, or in times of national or other emergency, call us to arrange for a medium-term supply of covered medications.
- **Why use generic drugs?** Generic drugs normally cost considerably less than brand name drugs. So, the copayment you pay for generic drugs is also lower. The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand name drugs must meet the same standards for safety, purity, strength and effectiveness. They are dispensed in the same dosage and taken in the same way. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name. If you receive a brand name drug when a Federally approved Tier 1 generic drug is available, *whether or not your physician has specified Dispense as Written* for the brand name drug, you have to pay the difference in cost between the brand name drug and the Tier 1 generic, unless your physician has obtained prior authorization for the brand name drug.

- **The Specialty Pharmacy Program**. Our comprehensive pharmacy and care management program for members using specialty drugs is designed to result in high patient satisfaction and positive health care outcomes. Specialty pharmacy focuses on medications that are used to treat somewhat rare, chronic and usually costly health conditions. Some of these conditions include: Asthma, Cancer, Crohn's disease, Gaucher's disease, Hemophilia, Hepatitis C, HIV/AIDS, Infertility, Multiple sclerosis, Primary immune deficiency, Psoriasis, Pulmonary arterial hypertension, Rheumatoid arthritis, Respiratory syncytial virus (RSV), and Organ/Tissue Transplant. The specialty pharmacy provides injected, infused or oral drugs that frequently require special administration, storage and handling. Medications are shipped directly to your home or other location you specify.

The specialty pharmacy does more than just provide medications. Its team of pharmacists, nurses and pharmacy care advocates work with you to achieve the best possible outcome from the medication treatment you receive. You don't have to manage your health condition alone. The specialty pharmacy's team of professionals is here to help:

- **Pharmacists**: The pharmacists are knowledgeable about conditions like yours. They can explain what to expect when you start a new therapy regimen or when the doctor orders a change. If you have questions about how the drug you're taking works, what the side effects are and if there are any possible interactions with other drugs you're taking, the pharmacists are trained to help. Pharmacists are available for urgent medication questions after hours too.
- **Nurses**: The nurses care about you and help track your medication therapy program through routine assessments. They can help you manage side effects and help you keep taking medications exactly as your doctor prescribes.
- **Pharmacy Care Advocates**: Whether you need a refill of the drug you're taking or you just want a resource in navigating diverse health insurance issues, pharmacy care advocates are here to help.
- **Reimbursement Specialists**: If you have the need, we have specialists to assist you with accessing medication assistance programs that help ensure certain vital medications are available to you.
- **Exceptions to the Specialty Pharmacy Program.** This requirement does not apply to:
  - The first two month's supply of a specialty pharmacy drug which is available through a member drugstore;
  - Drugs, which due to medical necessity, must be obtained immediately; or
  - A member is unable to pay for delivery of their medication (i.e., no credit card).
- **How to obtain an exception to the Specialty Pharmacy Program.** If you believe that you should not be required to get your medication through the Specialty Pharmacy Program, for any reasons listed above, you must complete an Exception to Specialty Drug Program form to request an exception and send it to Anthem Blue Cross and Blue Shield. The form can be faxed or mailed to Anthem Blue Cross and Blue Shield. If you need a copy of the form, you may call (800) 700-2541 to request one. You can also get the form on-line at www.anthem.com. If Anthem Blue Cross and Blue Shield gives you an exception, it will be in writing and will be good for 12 months from the time it is given. After 12 months, if you believe that you should still not be required to get your medication through the Specialty Pharmacy Program, you must again request an exception. If Anthem Blue Cross and Blue Shield denies your request for an exception, it will be in writing and will tell you why the exception was not approved.

We've made it simple to get started, if you choose the specialty pharmacy, there are easy ways to get started:

- **By phone**: Call (800) 870-6419 to verify your information. Pharmacy care advocates are available Monday through Friday, 8 a.m. to 9 p.m., Eastern Time.
- **By fax**: You can have your doctor fax your prescription(s) and a copy of your ID card to (800) 824-2642.

- **When you do have to file a claim.** Follow the same procedures for filing a prescription drug claim found on page 68.
- ***GenericSelect℠ Program.*** GenericSelect encourages the use of select generic medications by offering you a 30-day supply at a retail pharmacy and up to a 90-day supply through the mail order program with no copay on the first fill of each medication. If your physician believes the generic alternative is appropriate, he or she should write a new prescription for the generic medication. The program is available if you have not tried GenericSelect medications before. If you are currently taking a targeted brand medication you can try the generic counterpart at no cost. If you begin your medication therapy with a GenericSelect drug you may be eligible to receive the waived copay for your first prescription. If you receive the waived copay for the first prescription fill, standard copays will apply for subsequent refills.

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Drugs that under state law are dispensed only with a written prescription from a physician or other lawful provider • Insulin • Disposable needles and syringes for the administration of covered medications, including insulin • Drugs for sexual dysfunction (See Limited Drug Benefits below) • Diabetic test strips, lancets Please note: - You may receive up to a 90-day supply of maintenance medications at retail pharmacies that have agreed to participate in the mail order network and only pay the mail order copay. - Refills your doctor authorizes are covered for up to 12 months from the original prescription date. Then a new prescription is required. - Intravenous fluids and medication for home use are provided under home health services at no charge; and some injectable drugs are covered under Medical and Surgical Benefits. **Limited Drug Benefits** Prescription benefits for the treatment of sexual dysfunction will only be available with prior authorization where sexual dysfunction is secondary to a medical condition and the medical history and work-up is documented. You must receive prior authorization before receiving any prescription for the treatment of sexual dysfunction. If approved, six prescribed doses per month will be available and subject to the Tier 3 copayment. **Note: Specialty drugs must be obtained through the Specialty Pharmacy Program.** You cannot obtain specialty drugs from a retail pharmacy unless we have granted an exception. You cannot obtain a 90-day supply of specialty drugs because they are not available under the Mail Service Program.	**Retail (up to a 30-day supply)** Tier 1 - $5 Tier 2 - $40 Tier 3 - $60 Tier 4 - 25% of our allowance up to a maximum out-of-pocket of $150 per prescription order for a 30-day supply **Mail order and online (up to a 90-day supply)** Tier 1 - $12.50 Tier 2 - $100 Tier 3 - $150 **Tier 1 drugs** – Drugs offering the greatest value within a therapeutic class. Some of these are generic equivalents of brand name drugs. **Tier 2 drugs** – Drugs on this tier are generally the more affordable brand name drugs. Other drugs are on this tier because they are "preferred" within their therapeutic classes, based on clinical effectiveness and value. **Tier 3 drugs** – These are higher cost brand name drugs. Some Tier 3 drugs may have generics or equivalents in Tier 1. Some drugs on this tier may have been evaluated to be less cost effective than equivalent drugs on lower tiers. **Tier 4 drugs -** Many drugs on this tier are "specialty" drugs used to treat complex, chronic conditions and may require special handling and/or management. **Note:** If you purchase a brand name drug that has an equivalent Tier 1 drug, you will be responsible for the difference between the program's allowed charge for the Tier 1 drug and the equivalent brand name drug, in addition to the copay for the Tier 1 drug, unless your physician has obtained prior authorization for the brand name drug. This applies wherever the prescription is filled, at a network or non-network pharmacy, out-of-area, through mail order, or online.
• FDA approved drugs for the treatment of tobacco use. Note: This includes prescription and physician prescribed over-the-counter medications.	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• Women's contraceptive drugs and devices - The morning after pill when prescribed by a physician and purchased at a plan pharmacy.	Nothing
• Vitamin D for adults 65 and older	Nothing
GenericSelect[sm] Program includes: • 30-day supply of select generic medications at a retail pharmacy • 90-day supply of select generic medications through the mail order program For a listing of the GenericSelect drugs please contact customer service. Note: the copay waiver is only available when you fill a new prescription for a GenericSelect drug. Note: This program is only available to members who have not tried any of the GenericSelect medications in the past.	Nothing for your first prescription filled at a network retail pharmacy for one 30-day supply or a 90-day supply through the mail order program Note: Subsequent refills can be obtained at the Tier 1 copay from a network retail pharmacy or through the mail order program.
Not covered: • *Drugs for which there is a nonprescription equivalent available* • *Drugs obtained at a non-Plan pharmacy (except out-of-area emergencies)* • *Medical equipment, devices and supplies such as dressings and antiseptics* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs for weight loss purposes (except when authorized by the Plan doctor through the predetermination process for treatment of morbid obesity)* • *Nonprescription medicines* • *Replacement drugs due to loss or theft or travel* • *Special packaging for drugs in nursing homes* • *Food or food supplements* • *Vitamin Supplements are not covered except as stated above*	*All charges*

Section 5(g). Dental benefits

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.
- We do not have a calendar year deductible for services you receive under the HMO benefits.
- Please see Section 5(i) for information regarding POS benefits for Non-Network services. We will apply an annual deductible ($500 Self only or $1,500 Self and Family) and 30% coinsurance to covered POS services. You are also responsible for all charges that exceed our payment. Under POS, the annual catastrophic protection out-of-pocket maximum is $5,000 for Self only and $10,000 for Self and Family.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. Section 9 Coordinating benefits with Medicare and other coverage.
- Pre-approval or precertification must be obtained if Non-Network providers are used. Also read Section 5(d) about emergency services.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.

Benefit Description	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Network: Cost-share is based upon place of service. See specific benefit descriptions in Section 5. POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Dental benefits	**High Option**
We have no other dental benefits.	*All charges*

Section 5(h). Special features

Feature	Description
Feature	**High Option**
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. 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 in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • 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. • By approving an alternative benefit, we do not guarantee you will get it in the future. • 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. • 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 contract benefits will resume if we do not approve your request. Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Services for deaf and hearing impaired	For the hearing impaired (TDD), call (800) 822-1215.
Reciprocity benefit	**BlueCard® Program** With the BlueCard® Program, Plan members have access to benefits when traveling outside the Plan's service area for urgent care and emergency room services. To find a nearby health care provider, members can simply call BlueCard Access at (800) 810-BLUE (2583). **Guest Membership Program** We offer guest memberships at affiliated HMO Plans through the Guest Membership Program. Whenever you or a family member is away from our service area for more than 90 days, you may become a guest member at an affiliated HMO near your destination. Reasons to consider a guest membership include extended out-of-town business, children away at school, dependent children in another state, or a winter “snowbird” residency in the South. To determine if a guest membership is available at your destination, call (800) 355-6414.
Centers of excellence	We use the Blue Distinction Center for Transplants as our transplant network. The network consists of leading medical facilities throughout the nation. For a list of transplant hospitals near you, call (800) 824-0581. Blue Distinction Centers for Cardiac Care provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery (including coronary artery bypass graft surgery). To date, we have designated more than 410 Blue Distinction Centers for Cardiac Care across the country.
24-hour Tel-a-Nurse line	This is a free 24-hour phone service link to non-emergency health information. Simply call the toll-free number of (888) 220-3891 or (800) 877-8044 (TDD for those with hearing impairments) day or night to speak to a registered nurse. You also have access, through the internet www.myanthem.com, to receive customized health information.

Feature - continued on next page

Feature	Description
Feature (cont.)	**High Option**
Disease management	Anthem Blue Cross and Blue Shield is committed to helping you and your family stay well. We created Anthem's Health Promotion and Disease Management Programs to encourage awareness, healthy habits and regular doctor visits. To obtain information about these programs please visit our website at www.anthem.com. Our programs include but are not limited to: Asthma Care; Cardiac Care; Chronic Kidney Disease Program; Chronic Obstructive Pulmonary Disease (COPD) Program; Diabetes Care Program; and Maternity Care Program.

Section 5(i) Point of Service benefits

Facts about this Plan's POS option

Services which are not obtained from your PCP or another network provider, or not approved by Us as an authorized service will be considered a non-network service. Under the POS option, you may choose to obtain covered health services from non-network providers whenever you need care. When you obtain covered medical treatment from a non-network provider you will be responsible for the deductible and coinsurance plus any difference between the actual charge and the Plan's payment. The POS option applies to all covered services except the following:

- Prescription drugs
- Emergency services
- Chiropractic services
- Services when authorized by the Plan

You must remain within our provider network to obtain prescription drugs and chiropractic services. We provide emergency benefits for non-network providers as described in Section 5(d) Emergency Benefits.

Deductible

When you utilize the POS benefits you must meet the calendar year deductible of $500 Self only or $1,500 Self and Family before we begin paying for covered non-network services. The deductible will be based upon the Plan's maximum allowable amount for covered services.

Coinsurance

Once you have met the calendar year deductible, you owe 30% coinsurance for all covered POS services plus any difference between our payment and the billed charges. You are also responsible up to the billed charge for all non-covered services. We base our payment and your 30% coinsurance for covered services upon the maximum allowable amount for the covered services.

Out-of-pocket Maximum

The out-of-pocket maximum applies to covered POS services. After your deductible and coinsurance total $5,000 for Self only or $10,000 for Self and Family enrollment for covered non-network services, we will reimburse 100% of our maximum allowable charge and will no longer apply coinsurance for the remainder of the year to covered POS services. Please note that you will still be responsible for the difference between the actual charge and our payment which is based on the maximum allowable amount.

What is covered

• Diagnostic and treatment service	• Lab, X-ray and other diagnostic tests
• Preventive care, adult and child	• Maternity care
• Family planning	• Infertility services
• Allergy care	• Treatment therapies
• Physical, occupational and speech therapies	• Hearing and vision services
• Foot care	• Orthopedic and prosthetic devices
• Durable medical equipment (DME)	• Home health services
• Educational classes and programs	• Organ/tissue transplants
• Surgical procedures	• Reconstructive surgery
• Oral and maxillofacial surgery	• Anesthesia
• Inpatient hospital	• Outpatient hospital or ambulatory surgical center
• Extended care/Skilled nursing care facility	• Hospice care
• Emergency care in the office or urgent care center	• Mental health and substance abuse care

What is not covered

We will not cover the following services under POS:

- Chiropractic services
- Prescription drugs
- Services not specifically listed as covered
- Services for which a General Exclusion applies (see *Section 6 General Exclusions - things we don't cover*)
- Services for which you have no legal obligation to pay

Emergency services

When you experience a sudden or unexpected onset of a condition or injury that you believe endangers your life or could result in serious injury or disability, and requires immediate attention you should call 911 or go to the nearest emergency facility. Under the POS option your benefits will be considered at the in-network level regardless of status of the facility you are in. Your out-of-pocket expense will be the same as under the HMO option.

Prior approval and Precertification

Whether you remain within the network or seek covered care from outside the network, there are certain services that will require prior approval, precertification or predetermination. When you remain within the network, your network provider will contact us to obtain our authorization. However, when you seek covered non-network care, you are ultimately responsible for ensuring that your non-network provider has requested our prior approval or precertification. See page 20 for details.

Your responsibility for covered non-network services

What you pay often depends on the type of service you receive. If you receive covered services from a non-network provider you will be responsible for the difference between the actual charge and the Plan's maximum allowable amount:

- For covered services from non-network providers within the state of Missouri you will only be responsible for applicable deductible and coinsurance amounts.
- For covered services from non-network providers outside the state of Missouri you will be responsible for the difference between the actual charge and the Plan's maximum allowable amount in addition to any applicable deductible and coinsurance amounts.

However, these guidelines change when you receive covered services in a network provider facility, but from a non-network provider. If you go to a network hospital or provider facility and receive covered services from a non-network provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a network hospital or facility, you will be responsible for the **network** cost share amount (copayment or coinsurance). This is because you did not have a choice in selecting the provider employed by or contracted with the hospital or facility. In addition to any applicable deductible and coinsurance amounts you will be responsible for the difference between the actual charge and the Plan's maximum allowable amount when the provider is outside the state of Missouri.

If you choose to receive covered services from a non-network physician, when you could have selected a network physician, you will be responsible for the non-network cost share amount (deductible and/or coinsurance), and will be responsible to pay the difference between the non-network maximum allowable amount and the amount the non-network physician charges.

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 the FEHB out-of-pocket maximum. Your medical program copay does not apply to these services. You must pay for the services or supplies when you receive them.

Discount programs

SpecialOffers@Anthem

You can receive negotiated savings on selected health and wellness services and programs simply by being an eligible Anthem Blue Cross and Blue Shield Blue Preferred Plus POS member. To obtain information about these programs please call us at (888) 811-2092 or visit our website at www.anthem.com. Services available through the SpecialOffers@Anthem program include but are not limited to:

Beltone - save up to 50% off all Beltone hearing aids and receive a free hearing screening.

HearPO - save up to 40% on all audiological services and testing.

TruVision - savings on LASIK procedures.

Prescription Glasses - save up to 30% on a complete pair of prescription glasses, most sunglasses and lens options at thousands of providers nationwide. Discounts available at certain retailers such as; LensCrafters, Target Optical, JCPenney Optical and most Pearle Vision locations.

Jenny Craig - receive a free 30-day program or receive 25% off a Premium Program.

GlobalFit - save at over 10,000 gyms nationwide.

livinglean - a breakthrough weight-loss program that succeeds where all other diets and programs fail. It teaches you step-by-step how to permanently eliminate your emotional cravings for foods that make you unhealthy.

livingeasy - a program that creates calm where there was fear, fulfilling relationships where there was anger, and clarity where there was overwhelm.

livingfree - stop smoking without feeling deprived, denied, or irritable.

livingsmart - teaches you how to modify or eliminate alcohol use.

Section 6. General exclusions - services, drugs and supplies we do not 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 it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.** For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.*

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see page 53 for *Emergency services*).
- 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.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-Plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at (888) 811-2092.

How to file a claim:

- You can obtain claim forms by calling Client Services at (888) 811-2092. The back of the claim form has complete filing instructions.
- You can use the same claim form to file a claim for all your health care benefits, except for prescription drugs.
- You may submit claims for more than one person in the same envelope. *However, you must submit a separate claim form for each person.* Attach each person's bill to the correct form.
- Complete the claim form fully and accurately. You must check "yes" or "no" for each question. If you do not answer a question, we may have to return your claim to you. This is also true if you do not provide additional information required.
- When you write in your identification number on the claim form, be sure to include the first three digits.
- We can only accept itemized bills. Each bill must show: the name of the patient, the name and address of the provider of care, a description of each service and the date provided, a diagnosis and the charge for each service.
- Canceled checks and nonitemized bills that show only "balance due" or "for professional services rendered" are not sufficient.
- Include all bills for covered services not previously submitted.
- If you have paid the provider, mark each bill "paid."
- In some cases, we will pay you directly for covered services. In other cases, we will pay the provider.
- Please keep copies of the completed claim form and itemized bills.

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

Send your claims to the address shown below:

Blue Preferred Plus POS
P.O. Box 105187
Atlanta, GA 30348-5187

Prescription drugs

Major chains and independent pharmacies belong to your pharmacy network. At these pharmacies, if you show your Blue Preferred Plus POS ID card, you should only be responsible for paying your share of the cost. The pharmacy should file your claim, and we will pay the pharmacy directly.

At a Non-Network Pharmacy: If you go to a non-network pharmacy in an urgent or emergency situation outside the Blue Preferred Plus POS service area, you are responsible for paying for your prescription at the time of service and then filing a claim. Your program will not provide benefits if you use a non-network pharmacy within the Blue Preferred Plus POS service area.

You can obtain a Prescription Drug Claim Form by calling Client Services at (888) 811-2092.

You can file up to three prescriptions on each form. *Please do not use a regular health benefits claim form to file your prescription drug claim*. If you do, your claim may be denied.

- Please fill out a separate claim form for each person and pharmacy.
- Be sure to provide all the information requested for each prescription. You may need to have the pharmacy complete the form or get the information from the pharmacy.
- Then you or the pharmacist should fill out the pharmacy's name, address and National Association of Board of Pharmacy (NABP) number.
- On the completed form, *tape* your *original* itemized prescription drug receipt(s). Please do not send cash register receipts, canceled checks, bottle labels, copies of the original prescription drug receipts, or your own itemization of charges.
- The receipt(s) must show: the prescription number, the patient's name, the name of the drug, the quantity and unit dose, and the strength of the drug.

Sign the claim form and mail it along with your receipt(s) to the address shown below:

Express Scripts Inc.
Attn: Std Accounts
P.O. Box 66583
St. Louis, MO 63166-6583

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.anthem.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Blue Preferred Plus POS, Mail No. OH0402-B014, 1351 William Howard Taft Road, Cincinnati, Ohio 45206-1775 or calling (888) 811-2092.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Should you have a complaint, problem or question about your health plan or any services received, a Customer Service representative will assist you. Contact Customer Service by calling the number on the back of your member identification card.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Blue Preferred Plus POS, Mail No. OH0402-B014, 1351 William Howard Taft Road, Cincinnati, OH 45206-1775; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

Step	Description
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or. c) Ask you or your provider for more information 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. 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. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 2, 1900 E Street, NW, Washington, DC 20415-3620. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. 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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	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 file a lawsuit, 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 file a lawsuit 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 you did not indicate that your claim was a claim for urgent care, then call us at (888) 811-2092. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and 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 payor and the other Plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at http://www.NAIC.org.

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

When we are the secondary payor, we will determine our allowance. After the primary Plan pays, we will pay what is left of our allowance, up to our regular benefit. All programs together will not pay more than 100% of allowable expenses. The allowable expense is the maximum amount that a Plan will pay for covered services. We will not pay more than our allowance.

Please see Section 4, *Your cost for covered services*, for more information about how we pay claims.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and 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 (or a covered family member) 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 proceeding 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

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we pay benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if we provide benefits for that injury, you must agree to the following provisions:

- All recoveries you obtain (whether by lawsuit, settlement, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or, if applicable, to your heirs, administrators, successors, or assignees.
- We will not reduce our share of any recovery unless we agree in writing to a reduction, (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees. This is our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.
- If we pursue a recovery of the benefits we have paid, you must cooperate in doing what is reasonably necessary to assist us. You must not take any action that may prejudice our rights to recover.

You must tell us promptly if you have a claim against another party for a condition that we have paid or may pay benefits for, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the assignment.

Note: We will pay the costs of any covered services you receive that are in excess of any recoveries made.

The following are examples of circumstances in which we may subrogate or assert a right of recovery:

- When you or your dependent are injured on premises owned by a third party; or
- When you or your dependent are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:
  - Personal injury protection benefits
  - Uninsured and underinsured motorist coverage (does not include no-fault automobile insurance)
  - Workers' compensation benefits
  - Medical reimbursement coverage

Contact us if you need more information about subrogation.

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

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 www.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.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

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
- 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 (800) MEDICARE, (TTY: (877) 486-2048) 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 do not 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. 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. For people with limited income and resources, extra help in paying for a Medicare prescription drug Plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at (800) 772-1213 (TTY: (800) 325-0778).

- **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 (800) 772-1213 (TTY: (800) 325-0778) 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 do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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.

- **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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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. *You must continue to seek care from Plan providers and you will still be responsible for the Plan's copayments.*

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 this Plan is the primary payor and you have a claim for covered services that you must file yourself, please follow the claim filing instruction in Section 7.

Once you receive an Explanation of Benefits (EOB) from us, then file a claim for your Medicare benefits. *(For information on filing a Medicare claim, contact your Social Security office.)*

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. *(Please note that we will utilize the Medicare allowable amount when we provide the secondary benefit for covered services.)* However, you should file a claim if you receive services or supplies that are not covered by Medicare but are covered by this program. To find out if you need to do something to file your claim, call us at (888) 811-2092 or see our website at www.anthem.com.

You should *not* submit a claim for benefits of this program if your Medicare Summary Notice (MSN) states, in part: "This information is being sent to your private insurer." This note means that the Medicare carrier is submitting your claim to us. Then we can provide the benefits of this program. If this note is on your MSN, please do *not* submit a claim to us. Also, please let your providers of care know that they should *not* submit your claim to us. When we receive duplicate claims, this increases costs. Your MSN may not indicate that your claim has been referred to supplemental claims processing. In that case, you should file your own claim.

We do not waive any costs if the Original Medicare Plan is your primary payor.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **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 (800) MEDICARE ((800) 633-4227), (TTY: (877) 486-2048) or at www.medicare.gov.

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

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). However, we will not waive any of our copayments. 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 payor, we process the claim first. If you enroll in Medicare Part D, and we are the secondary payor, 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 payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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 Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor 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 payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor 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.

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.

Clinical Trials Cost

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

The percentage of our allowance that you must pay for your care. See page 25.

Copayment

A fixed amount of money you pay when you receive covered services. See page 25.

Cost-sharing

The general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive. See page 25.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Services that do not seek to cure, but are provided primarily for the convenience of the patient or his or her family, the maintenance of the patient, or to assist the patient in meeting his or her activities of daily living, rather than primarily for therapeutic value in the treatment of a condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, eating, preparation of special diets, supervision over self-administration of medications not requiring constant attention of trained medical personnel, or acting as a companion or sitter. Custodial care that lasts 90 days or more is sometimes known as Long term care.

Note: Blue Preferred Plus POS will have the sole discretion to determine whether care is Custodial care. Blue Preferred Plus POS may consult with professional peer review committees or other appropriate sources for recommendations.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. See page 25.

Experimental or investigational service

A drug, device or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully 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.

An FDA-approved drug, device or biological product (for use other than its intended purpose and labeled indications), or medical treatment or procedure 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, or

2) Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure 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 authorized 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.

FDA-approved drugs, devices, or biological products used for their intended purpose and labeled indication and those that have received FDA approval subject to postmarketing approval clinical trials, and devices classified by the FDA as "Category B Non-experimental/ Investigational Devices" are not considered experimental or investigational.

New Treatments and Procedures – Helping our members get care that is safe and effective

When it comes to the latest information about medical care, we want you to know that we strive to review it quickly. We have teams of healthcare professionals that review our medical, behavioral (mental) health and drug policies on a regular basis. The resources we look to when making our decisions include:

- Professional medical publications and journals
- Policies and procedures from government agencies
- Study results showing the impact of new technology on long-term health
- Doctors, specialists and other health care consultants

We update our health policies and even create new ones to address many new treatments. Because helping you get and stay healthy is our number one goal.

Group health coverage

A health benefit Plan that is offered to employees through their place of employment or to the membership of a sponsoring organization such as a union or association.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Maximum allowable amount

The amount that We determine is the maximum payable for covered services you receive. Generally, to determine the maximum allowable amount for a covered service, We use, in addition to other information, internally developed criteria and industry accepted methodologies and fee schedules which are based on estimates of resources and costs required to provide a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.

For a network provider, the maximum allowable amount is equal to the amount that constitutes payment in full under the network provider's participation agreement for this Plan. If a network provider accepts as full payment an amount less than the negotiated rate under the participation agreement for this Plan, the lesser amount will be the maximum allowable amount.

For a non-network provider who is a physician or other non-facility provider, even if the provider has a participation agreement with Us for another plan, the maximum allowable amount is the lesser of the actual charge or the standard rate under the participation agreement used with network providers for this Plan.

For a non-network provider that is a facility, the maximum allowable amount is equal to an amount negotiated with that non-network provider facility for covered services under this Plan or any other plan. In the absence of a negotiated amount, We shall have discretionary authority to establish, as We deem appropriate, the maximum allowable amount. The maximum allowable amount is the lesser of the non-network provider facility's charge, or an amount determined by Us, after consideration of one or more of the following: industry cost, peer reimbursement, utilization data, previously negotiated rates, outstanding offers that We may have made, or other factors We deem appropriate. It is your obligation to pay any deductibles, coinsurance and/or copayments.

Medical necessity

We only cover care that is medically necessary. But we do not cover all medically necessary care. Even if the type of care is covered in general, the care is not covered if we determine it was not medically necessary in a specific case. Blue Preferred Plus POS must agree that care was medically necessary.

However, in some cases, you will not have to pay for care that was not medically necessary. In these cases, the provider is responsible. You do not need to pay if *all* of the following are true:

Blue Preferred Plus POS did not notify you in advance that the care was not medically necessary.

The services would have been covered if they were medically necessary.

To be medically necessary, care must be provided to diagnose or treat a condition. Also, the type and level of care must be necessary and appropriate. We use current standards of medical practice to decide necessity and appropriateness. The type and level of care must not be more than what is necessary.

For example, surgery may not be medically necessary for your condition if your provider has not tried more conservative treatment. Also, inpatient care is not medically necessary if appropriate care is available on an outpatient basis.

Network Provider

A provider who has entered into a contractual agreement or is being used by us, or another organization, which has an agreement with us, to provide covered services and certain administrative functions for the Blue Preferred® Plus POS network.

Non-network Provider

A provider who has not entered into a contractual agreement with us for Blue Preferred® Plus POS. Providers who have not contracted or affiliated with our designated subcontractor(s) for the services they perform are also considered non-network providers.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Specialist

For purposes of this Plan, a specialist is any provider other than your Primary Care Physician (PCP). The term specialist would include licensed or certified physical, occupational or speech therapists in addition to medical doctors, psychologists, etc. A $40 office visit copay applies to the services of specialists.

Urgent care claims

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

	If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at (888) 811-2092. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
Us/We	Us and We refer to Blue Preferred Plus POS.
You	You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no Government contribution.

Important information about 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. Participating employees save an average of about 30% on products and services they 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 reimbursed. 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 $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- Health Care FSA (HCFSA) – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan .
- **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 out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA** – Reimburses you for eligible **non-medical** day care expenses for your children 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.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at (877) FSAFEDS ((877) 372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: (800) 952-0450.

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

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is, separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.** FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including: • 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 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**
Vision Insurance	All 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/dental and www.opm.gov/vision. These sites also provide 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 (877) 888-3337 (TTY: (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 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 such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call (800) LTC-FEDS ((800) 582-3337) (TTY: (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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Summary of benefits for Blue Preferred Plus POS - 2015

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and 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.
- Under the POS benefits for non-network care, you must satisfy an annual deductible ($500 Self only or $1,500 Self and Family) and 30% coinsurance for all covered services.

Benefits	You pay (HMO option only)	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Network: $20 per office visit to your primary care physician or $40 per office visit to a specialist POS Non-network: After satisfying the annual deductible, 30% coinsurance	30
• Lab, X-ray and other diagnostic tests	Network: Nothing POS Non-network: After satisfying the annual deductible, 30% coinsurance	31
• CT Scans, MRI, MRA, PET, nuclear cardiology imaging studies, and non-maternity related ultrasounds	Network: $150 per test POS Non-network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed amount	31
Services provided by a hospital:		
• Inpatient	Network: $500 per admission POS Non-network: After satisfying the annual deductible, 30% coinsurance	50
• Outpatient	Network: $200 per visit (Facility copay only applies when surgical procedure is performed.) POS Non-network: After satisfying the annual deductible, 30% coinsurance	51
Emergency Benefits • In-area or out-of-area	$150 per emergency room visit	54
Mental health and substance abuse treatment:	Regular cost-sharing	55
Prescription drugs:		
• Retail pharmacy - Up to a 30-day supply from a participating retail pharmacy Note: You must obtain Tier 4 specialty medication from our Specialty Pharmacy Program.	Tier 1: $5 Tier 2: $40 Tier 3: $60 Tier 4: 25% of our allowance up to a maximum of $150	59

Benefits	You pay (HMO option only)	Page
• Mail order - Up to a 90-day supply of maintenance medication Note: Tier 4 medication is not available through the mail-order pharmacy.	Tier 1; $12.50 Tier 2: $100 Tier 3: $150	59
Dental care: Accidental injury only	Copay or coinsurance is based on place of service	61
Vision care: • Routine eye exam or refraction (one per calendar year)	Network: Routine eye exam or refraction (one per calendar year); $20 per office visit to your Primary Care Physician (PCP) or $40 per office visit to a Specialist POS Non-network: After satisfying the annual deductible, 30% coinsurance	37
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Protection against catastrophic costs (out-of-pocket maximum)**:**	Network: $3,500 Self Only or $7,000 Self and Family per year. POS Non-network: $5,000 Self only or $10,000 Self and Family per year.	25

2015 Rate Information for Blue Preferred Plus POS

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the Guide to Federal Benefits for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to Postal Service employees. They are shown in special Guides published for APWU (including Material Distribution Center and Operating Services) NALC, NPMHU and NRLCA Career Postal Employees (see RI 70-2A); Information Technology/Accounting Services employees (see RI 70-2IT); Nurses (see RI 70-2N); Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees and Postal Career Executive Service employees (see RI 70-2IN); and non-career employees (see RI 70-8PS).

Postal Category 1 apply to career employees who are members of the APWU, NALC, NPMHU, or NRLCA bargaining units.

Postal Category 2 rates apply to career non-bargaining unit, non-executive, non-law enforcement employees, and non-law enforcement Inspection Service and Forensics employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center
(877) 477-3273, option 5
TTY: (866) 260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable Guide to Federal Benefits.

Premiums for Tribal employees are shown under the monthly non-postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	9G1	$202.01	$199.18	$437.69	$431.56	$185.15	$199.18
High Option Self and Family	9G2	$448.57	$353.82	$971.90	$766.61	$322.67	$353.82