Blue Open Access POS

www.bcbsga.com

Customer Service 844-423-9988

2018

A Health Maintenance Organization with a 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. This plan is accredited. See page 12.

Serving: Atlanta Metro and Athens areas

Enrollment in this Plan is limited. You must live in our geographic service area to enroll. See page 13 for requirements.

IMPORTANT
- Rates: Back Cover
- We are new for 2018.
- Summary of benefits: Page 84

Enrollment codes for this Plan:
QM1 High Option Self Only
QM3 High Option Self Plus One
QM2 High Option Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from Blue Open Access POS
About Our Prescription Drug Coverage and Medicare

OPM has determined that the Blue Open Access 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 Open Access POS under our contract (CS 2953) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 844-423-9988 or through our website: www.bcbsga.com. This Plan is underwritten by Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. The address for the Blue Open Access POS administrative office is:

Blue Open Access POS
Mail No. GA082E-0007
6087 Technology Pkwy
Midland, GA 31820

This brochure is the official statement of benefits. No 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. If you enroll in Self Plus One coverage, you and one eligible family member whom you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2018, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each Plan annually. Benefit changes are effective January 1, 2018. 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.

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 Open Access 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/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

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 (TCC).
- 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.

Discrimination is Against the Law

The Blue Open Access POS complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, the Blue Open Access POS does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

For the translation of this statement in: Spanish, Chinese, Vietnamese, Korean, Tagalog, Russian, Arabic, Armenian, Farsi, French, Japanese, Haitian, Italian, Polish, Punjabi, and Navajo please visit our website at www.bcbsga.com.

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 800-368-1019 (TDD: 800-537-7697) or online at ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. 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 take notes, 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.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic 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 or clinic.

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

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. 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.bemedwise.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.

Preventable Healthcare Acquired Conditions ("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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

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. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error. Should an event occur and you were required to make payments to the provider you will be reimbursed for your out-of-pocket costs. The Plan considers Never Events to include 2 categories: major surgical never events or Hospital Acquired Conditions (HAC) as defined by The Centers for Medicare & Medicaid Services (CMS).

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 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.

- **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 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 Plus One coverage is an enrollment that covers you and one eligible family member. 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 or Self Plus One 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 Plus One or 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 Plus One or 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 are married.

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. A Self Plus One enrollment covers you and your spouse, or one eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren 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.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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 Plus One or 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 in Self Plus One or 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 Plus One or Self and Family coverage, as appropriate, 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 Plus One or Self and Family, as appropriate, 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 Plus One or Self and Family, as appropriate, 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. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. 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 2018 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 2017 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 additional information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information/.

- **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, 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 contact us in writing 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 contact us 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, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 844-423-9988 or visit our website at www.bcbsga.com.

- **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

This Plan is a Health Maintenance organization (HMO) with a Point of Service (POS). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Blue Open Access POS holds the following accreditations: Accredited status with NCQA and Full status with URAC for UM. To learn more about this plan's accreditation(s), please visit the following websites: National Committee for Quality Assurance (www.ncqa.org) and URAC (www.URAC.org).

We require you to see specific physicians, hospitals, and other providers that contract with us. Our Plan providers will coordinate your health care services. When you receive services from network providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. However, if you use non-network providers you may be responsible for filing claims and may be required to pay for the charges at the time of services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory.

Blue Open Access POS emphasizes 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.

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.

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a network provider without a referral.

We have Point of Service (POS) benefits option

Our Plan offers Point-of-Service (POS) benefits. This means you can receive covered services from a non-network provider. However, out-of-network benefits may have higher out-of-pocket-costs than our in-network benefits.

How we pay providers

Network Providers

We negotiate rates with doctors and other health care providers. We refer to these providers as "Network Providers". These negotiated rates are our Plan allowances for network providers. We calculate your coinsurance using these negotiated rates. You are not responsible for amounts billed by network providers that are greater than our Plan allowance.

Non-Network Providers

Because they do not participate in our networks, non-network providers are paid based on an out-of-network Plan allowance. You are responsible for the deductible, coinsurance or copayment, as well as the difference between our allowance and the billed charge.

Your rights and Responsibilities

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/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence
- Profit status

- 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

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, Blue Open Access POS at www.bcbsga.com. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 844-423-9988, or write to Blue Open Access POS, Mail Location: GA082E-0007, 6087 Technology Pkwy, Midland, GA 31820. You will find important information about your member rights and responsibilities, and how we evaluate new technology for covered services at www.bcbsga.com. Go to Customer Support, then go to FAQs. You may also visit our website at www.bcbsga.com/federal/ga/.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our website at www.bcbsga.com. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

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

Service Area

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

Atlanta metro area counties: Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Haralson, Heard, Henry, Lamar, Meriwether, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton.

Athens area counties: Clarke, Madison, Oconee, and Oglethorpe

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. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

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) *Wellness and Other Special Features* on page 57 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.

Section 2. Changes for 2018

This is a new Plan for 2018. Please familiarize yourself with the benefits and limitations of the Plan.

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 844-423-9988 or write to us at Blue Open Access POS, Mail Location: GA082E-0007, 6087 Technology Pkwy, Midland, GA 31820. You may also request replacement cards through our website at www.bcbsga.com.

Where you get covered care

When you get care from "Plan providers" and "Plan facilities". You will only pay your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies), if you use our point-of-service program, you can also get care from non-Plan providers but it will cost you more. Under the Blue Open Access POS you can receive covered services from a participating provider without a referral.

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.bcbsga.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 list is also on our website.

- **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

This 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. This 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 page 17. 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 a Blue Open Access POS 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**

Your primary care physician can be a general or family practitioner, internist, or pediatrician. Your PCP will provide most of your health care.

- **Specialty care**

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

Here are some things you should know about specialty 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.

- **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 844-423-9988. 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

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*.

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.

- **Transgender services**

  Transgender services require prior Plan approval to be covered. For the Plan to consider benefit coverage, you must have met each of the following requirements:

  - Be 18 years of age
  - Have the capacity to make fully informed decisions and consent for treatment
  - Have been diagnosed with gender dysphoria
  - Have reasonably controlled medical or mental health issues
  - Have two qualified mental health referrals

  Along with the requirements above, some surgeries have additional criteria and specifications that include, but are not restricted to the list below:

  - Undergone 12 months of continuous hormonal therapy
  - Completed at least 12 months of documented successful real-life experience in their new gender
  - Participated in psychotherapy during the real-life experience when recommended by treating medical or behavioral practitioner

  Gender reassignment surgery is considered not medically necessary when one or more of the criteria has not been met. For details on the medical necessity criteria contact Us at 844-423-9988.

- **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 need services and a network provider is not available, we will provide authorization to seek care from a non-network provider. In this case, the services that are authorized will be treated as in-network services and paid accordingly.

  If you seek covered care from non-network providers under Blue Open Access POS, 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 for a normal delivery)
  - Newborn stays that go beyond the discharge of the mother
  - Transplants (Human Organ and Bone Marrow/Stem Cell)
  - Diagnostic Imaging such as, but not limited to: Computed Tomography (CT), Computed Tomographic Angiography (CTA), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Nuclear Cardiology and Positron Emission Tomography (PET)
  - Certain Cardiovascular services such as, but not limited to: Cardiac Catheterization with Coronary Angiography, Echocardiograms, Arterial Ultrasound and Percutaneous Coronary Intervention (PCI)
  - Certain Radiation Therapy services such as, but not limited to: Intensity Modulated Radiation therapy (IMRT), Proton Beam radiation Therapy, Brachytherapy, Image Guided Radiation Therapy (IGRT) in association with External Beam Radiation Therapy
  - Outpatient Sleep Testing and Therapy services
  - Bariatric Surgery and other treatments for Clinically Severe Obesity

- Behavioral Health and Substance Abuse Services for Intensive Outpatient programs (IOP), Partial Hospitalization Programs (PHP), Transcranial Magnetic Stimulation for Depression, and Residential Treatment
- Prosthetic Devices
- Powered Devices such as, but not limited to: mobility devices or robotic lower body exoskeleton devices
- Reconstructive surgery
- Transgender services
- Treatment of temporomandibular (TMJ) disease

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 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 let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the 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 844-423-9988. 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 844-423-9988. 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.

Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **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

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 a Blue Open Acccess POS 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 Blue Open Access POS benefits before we start paying for covered services from out of network providers. Under the Blue Open Access POS Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $2,000. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $4,000. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $6,000.
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 Blue Open Access 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	**For covered network services** - after your network copayments and coinsurance totals $4,000 for Self Only or $4,000 per person for Self Plus One, or $8,000 for Self and Family enrollment for medical services in any calendar year, you do not have to pay any more for covered medical services. **For covered non-network services** - after your deductible and coinsurance totals $8,000 for Self Only or $8,000 per person for Self Plus One, or $16,000 for Self and Family enrollment, you do not have to pay any further deductible and/or coinsurance for covered medical services. However, you may be 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 coinsurance since you are responsible for informing us when you reach the maximum.

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

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Section 5. Benefits Overview

This Plan offers a High Option. The benefit package is described in Section 5. Make sure that you 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 844-423-9988 or on our website at www.bcbsga.com.

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

- No referrals needed for care from network providers
- No deductible
- Out-of-pocket maximums of $4,000 for Self Only or $4,000 per person for Self Plus One, or $8,000 for Self and Family
- 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
- $250 copay per day for a maximum of 4 days per inpatient admission
- $300 outpatient facility copay for surgery
- $200 copay per visit to the emergency room
- Retail pharmacy (30-day supply) Level 1 copays of $5 for Tier 1, $60 for Tier 2, or $100 for Tier 3
- Retail pharmacy (30-day supply) Level 2 copays of $15 for Tier 1, $70 for Tier 2, or $110 for Tier 3
- Mail order (90-day supply) copays of $10 for Tier 1, $150 for Tier 2, or $250 for Tier 3
- Tier 4 drugs are 25% of our allowance up to a maximum out-of-pocket of $250 per prescription for a 30-day supply

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

- Freedom of choice when accessing covered care from non-network providers
- After the annual deductible of $2,000 for Self Only, $2,000 per person for Self Plus One or $6,000 for Self and Family you pay 30% coinsurance for covered services
- When your out-of-pocket expenses for covered non-network services add up to $8,000 for Self Only, $8,000 per person for Self Plus One or $16,000 for Self and Family, we eliminate the 30% coinsurance for covered services.

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.
- There is a calendar year deductible for covered out-of-network services. The deductible is $2,000 for Self Only, $2,000 per person for Self Plus One and $6,000 for Self and Family enrollment.
- The facility copayment or 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.
- 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
• Injectable or infused medications given by the doctor in the office Note: This does not include immunizations prescribed by your primary care physician nor allergy injections.	Network: 20% of our allowance POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• 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

Benefit Description	You pay
Telehealth	**High Option**
Online clinic visit Note: Online clinic visits include visits with your physician or with a provider through LiveHealth Online. To get started visit the website at www.livehealthonline.com.	$20 per visit
Lab, X-ray and other diagnostic tests	**High Option**
Laboratory tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology Diagnostic tests, such as: • 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 (including CTA), MRI, MRA, PET, MRS, nuclear cardiology imaging studies and non-maternity related ultrasounds Note: Prior approval is required. See Section 3.	Network: 20% of our allowance 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 • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Routine Pap test – annual • Screening for obesity and referrals for behavior change interventions for adults with a Body Mass Index (BMI) over 30kg/m2	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Well woman care; based on current recommendations such as: • Cervical cancer screening (Pap smear) • Human Papillomavirus (HPV) testing • Chlamydia/Gonorrhea screening • Osteoporosis screening • Breast cancer screening • Counseling for sexually transmitted infections • Counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling	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**
• Screening and counseling for interpersonal and domestic violence • Routine mammogram – covered for women	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html **Women's preventive services:** www.healthcare.gov/preventive-care-women/ For additional information: healthfinder.gov/myhealthfinder/default.aspx	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Preventive care, children	**High Option**
Well-child visits, examinations, and immunizations as described in the Bright Future Guidelines provided 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
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/	

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**High Option**
HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html For additional information: healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to brightfutures.aap.org/Pages/default.aspx	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women after 24 weeks. • Delivery • Postnatal care	Network: $20 per visit (office visit copay applies to the first prenatal visit) Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Breastfeeding support, supplies and counseling for each birth	Nothing
Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see page 17 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • 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 Plus One or 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. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	

Benefit Description	You pay
Family planning	**High Option**
Contraceptive counseling	Nothing
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5(b)) • Surgically implanted contraceptives • Injectable contraceptive drugs and patches • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under Section 5(f) *Prescription drug benefits.*	Network: Nothing for family planning services, otherwise $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 surgical sterilization* • *Genetic testing and counseling*	*All charges*
Infertility services	**High Option**
• Services limited to: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	Network: Nothing for infertility services, otherwise $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: • *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* • *Fertility drugs*	*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 and 20% of our allowance for testing and treatment POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge

Allergy care - continued on next page

Benefit Description	You pay
Allergy care (cont.)	**High Option**
• Allergy injections	Network: $5 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. 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 39-43.	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist plus 20% of our allowance 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 visit or $40 per outpatient facility 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 performed in a physician's office	Network: $20 per PCP visit or $40 per Specialist visit and 20% of our allowance 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 through age six. Note: Applied Behavior Analysis (ABA) Therapy is limited to a maximum of $30,000 per year for members through age six.	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: • *Therapy that is not listed as covered in this booklet. For example, massage therapy or exercise conditioning.*	*All charges*

Benefit Description	You pay
Physical, occupational and speech therapies	**High Option**
20 visits of rehabilitative and habilitative physical, occupational and speech therapy per calendar year by: • Occupational therapists • Speech therapists • Physical therapists	Network: $20 per visit to your PCP or $40 per visit to a Specialist or $40 per outpatient facility visit POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• Cardiac rehabilitation - 36 visits when rendered as physician home visits and office services or outpatient services, unless additional visits are approved by Us in advance. • Pulmonary rehabilitation - 20 visits when rendered as physician home visits and office services or outpatient services, unless additional visits are approved by Us in advance.	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist or $40 per outpatient facility visit 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*
Hearing services (testing, treatment, and supplies)	**High Option**
• Routine hearing screening • Newborn hearing screenings, re-screenings, audiology assessment and follow-up	Network: Nothing for screenings, otherwise $20 per visit to your PCP or $40 per 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**
Medical and surgical treatment of injuries and/or diseases affecting the eye	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
The first pair of eyeglasses, including frames, or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist plus 20% 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: • *Eye exercises and vision training* • *Radial keratotomy and other refractive surgery* • *Photo-Refractive keratectomy (PRK)*	*All charges*

Benefit Description	You pay
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: • *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**
Covered services may include, but are not limited to: • Artificial limbs and accessories • One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes • 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. • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: Benefits include purchase, fitting, adjustments, repairs and replacements. 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 plus 20% coinsurance 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 cancer treatment	Network: Nothing up to a $175 maximum benefit 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*

Benefit Description	You pay
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 • Blood glucose monitors • Medical supplies, such as surgical dressings and colostomy bags and casting supplies Note: Rental cost must not be more than purchase price.	Network: $20 per office visit to your PCP or $40 per office visit to a Specialist plus 20% coinsurance POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft* • *Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury* • *Non-Medically Necessary enhancements to standard equipment and devices* • *Supplies, equipment and appliances that include comfort, luxury, or convenience items*	*All charges*
Home health services	**High Option**
Up to 100 visits per calendar year including but not limited to: • Intermittent Skilled Nursing Services (by an R.N. or L.P.N.) • Medical/Social Services • Diagnostic Services • Nutritional Guidance • Home Health Aide Services - The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider. • Therapy Services • Medical/Surgical Supplies • Durable Medical Equipment Note: To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge

Home health services - continued on next page

Benefit Description	You pay
Home health services (cont.)	**High Option**
• Private Duty Nursing for up to 82 visits per calendar 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: • *Food, housing, homemaker services and home delivered meals* • *Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider* • *Manipulation therapy*	*All charges*
Chiropractic	**High Option**
Up to 26 visits per calendar year including: • Diagnostic testing • Manipulations • 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
Not covered: • *Maintenance therapy* • *Nutritional or dietary supplements, including vitamins* • *Cervical pillows* • *Spinal decompressions devices such as: Vertebral Axial Decompression (Vax-D) and DRX9000*	*All charges*
Alternative treatments	**High Option**
No benefit.	*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 drug 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
• Diabetes Note: Diabetes self management training is covered for an individual with insulin dependent diabetes, noninsulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition.	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
• Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder through age six	Network: $20 per visit to your PCP or $40 per visit to a Specialist

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
Note: Applied Behavior Analysis (ABA) Therapy is limited to a maximum of $30,000 per year for members through age six.	Network: $20 per visit to your PCP or $40 per 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: • *Any educational service not listed above as covered*	*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.
- Plan physicians must provide or arrange your care within the network.
- There is a calendar year deductible for covered out-of-network services. The deductible is $2,000 for Self Only, $2,000 per person for Self Plus One and $6,000 for Self and Family enrollment.
- 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 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.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative and cutting procedures • Treatment of fractures and dislocations, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Correction of congenital anomalies (see Reconstructive surgery) • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information 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 POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• Surgical treatment of morbid obesity (bariatric surgery)	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Transgender reassignment surgeries consisting of any combination of the following: • hysterectomy, salpingo-oophorectomy; ovariectomy, orchiectomy, metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, placement of testicular prostheses or bilateral mastectomy. Note: Prior authorization is required. See Section 3 *How you get care* for more information.	Network: Nothing 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**
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Enhancements related to gender reassignment, including: abdominoplasty, blepharoplasty, breast augmentation, brow lift, calf implants, electrolysis, face lift, facial bone reconstruction, facial implants, gluteal augmentation, jaw reduction (jaw contouring), lip reduction/enhancement, lipofilling/collagen injections, liposuction, nose implants, pectoral implants, rhinoplasty, thyroid cartilage reduction (chondroplasty), voice modification surgery, or voice therapy*	*All charges*
Reconstructive surgery	**High Option**
• Surgery performed to correct significant deformities caused by congenital or developmental abnormalities, illness, injury, or an earlier treatment in order to create a more normal appearance. • Mastectomy or follow-up care for a mastectomy and breast reconstruction was chosen: - Reconstruction of the breast on which the mastectomy has been performed; - Surgery and reconstruction of the other breast to give symmetrical appearance; and - Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas. 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 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.*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures include: • Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part. • Oral/surgical correction of accidental injuries. • Treatment of non-dental lesions, such as removal of tumors and biopsies. • Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses. • Surgical correction of anatomical abnormalities for treatment of temporomandibular (TMJ) disease when approved in advance. • Other surgical procedures that do not involve the teeth or their supporting structures.	Network: Nothing 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**
Note: We will cover general anesthesia in conjunction with covered oral surgical procedures only for patients as indicated below: • Member is under the age of 7; • Member has a chronic disability that is attributable to a mental and/ or physical impairment which results in substantial functional limitation in an area of the Member's major life activity, and the disability is likely to continue indefinitely; or • Member has a medical condition that requires hospitalization or general anesthesia for dental care.	Network: Nothing POS Non-network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
Not covered: • *Oral implants and transplants* • *Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as otherwise listed*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart-lung • Kidney • Kidney-Pancreas • 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
Blood or Marrow Stem Cell Transplants: 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	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**
• Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) • Hemoglobinopathy • 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 • Hodgkin's lymphoma relapsed or refractory • Non-Hodgkin's lymphoma relapsed or refractory • Amyloidosis • Breast Cancer • Epithelial ovarian cancer • 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 as shown above: 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
Tandem transplants for covered transplants: subject to medical necessity review by the Plan • Autologous tandem transplants for: - 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

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
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: Subject to Medical Necessity. 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) • Breast cancer • 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
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) • Multiple sclerosis • Beta Thalassemia Major Non-myeloablative allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Non-Hodgkin's lymphoma - relapsed or refractory • Chronic lymphocytic leukemia • Chronic myelogenous leukemia • Chronic lymphocytic lymphoma/small lymphoma (CLL/SLL) • Early stage (indolent or non-advanced) small cell lymphocytic 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**
• Multiple myeloma (after a previous autologous stem cell transplant or due to primary graft failure, failure to engraft or rejection) • Multiple sclerosis • Myeloproliferative Disorders • Myeloproliferative/Myelodysplastic Syndromes • Sickle Cell disease Autologous transplants for the following autoimmune diseases: • Multiple sclerosis • Systemic lupus erythematosus • Systemic sclerosis • Scleroderma • Scleroderma-SSc (severe, progressive) Autologous transplants for: • Chronic myelogenous Leukemia (after allogeneic transplant) • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) (after allogeneic transplant) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma (after allogeneic transplant)	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 • 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
All care for transplants must be coordinated through Blue Open Access POS's transplant department.	

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
Transportation and lodging, covered, as approved by us, up to a $10,000 benefit limit per transplant. Benefits are based upon current limits set forth in the Internal Revenue Code. This must be approved in advance by us.	
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	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• 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
Note: We will cover general anesthesia in conjunction with covered oral surgical procedures only for patients as indicated below: • Member is under the age of 7; • Member has a chronic disability that is attributable to a mental and/ or physical impairment which results in substantial functional limitation in an area of the member's major life activity, and the disability is likely to continue indefinitely; or • Member has a medical condition that requires hospitalization or general anesthesia for dental care. The general anesthesia must be provided in a hospital, freestanding surgery center or dentist's office. The dental procedures themselves are not covered.	

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.
- Plan physicians must arrange your care
- There is a calendar year deductible for covered out-of-network services. The deductible is $2,000 for Self Only, $2,000 per person for Self Plus One and $6,000 for Self and Family enrollment.
- 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 PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	**High Option**
Covered services include acute care in a hospital setting. Benefits for room, board and nursing services include: • A room with two or more beds • A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available. • A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients. • Routine nursery care for newborns during the mother's normal hospital stay. • General nursing care • Meals and special diets	Network: $250 copay per day for a maximum of 4 days per inpatient 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, childbirth, and treatment rooms and equipment • Prescribed drugs • Anesthesia, anesthesia supplies and services given by the Hospital or other Provider • Medical and surgical dressings, supplies, casts and splints • Diagnostic services • Therapy services, including infusion therapy services	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* • *Non-covered facilities, such as schools*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
• *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Surgical rooms and equipment • Prescribed drugs including Specialty Drugs • Diagnostic services • Medical and surgical dressings and supplies, casts, and splints • Anesthesia and anesthesia supplies and services given by the hospital or other facility	Network: $300 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
Other non-surgical care	Network: 20% of our allowance POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge.
• CT Scans (including CTA), MRI, MRA, PET, MRS, nuclear cardiology imaging studies and non-maternity related ultrasounds Note: Prior approval is required. See Section 3. Note: Central supply (IV tubing) and pharmacy (dye) necessary to perform tests are covered as part of the test.	Network: 20% of our allowance 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: $250 copay per day for a maximum of 4 days 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 6 months or less. Your Doctor must agree to care by the Hospice and must be consulted in the development of the treatment plan. The Hospice must keep a written care plan on file and give it to us upon request. Covered services include: • Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care • Short-term Inpatient Hospital care when needed in periods of crisis or as respite care • Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse	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**
• Social services and counseling services from a licensed social worker • Nutritional support such as intravenous feeding and feeding tubes • Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist • Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies • Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.	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**
Medically necessary ambulance services when one or more of the following criteria are met: • You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation. • For ground ambulance, you are taken: - From your home, the scene of an accident or medical emergency to a hospital; - Between hospitals, including when we require you to move from a non-network hospital to a network hospital; or - Between a hospital and a skilled nursing facility or other approved facility. Note: All scheduled ground ambulance services for non-emergency transfers, except transfers from one acute facility to another, must be approved through precertification. Benefits will be limited to $50,000 per occurrence if a non-network provider is used. • For air and water ambulance, you are taken: - From the scene of an accident or medical emergency to a hospital; - Between hospitals, including when we require you to move from a non-network hospital to a network hospital; or - Between a hospital and an approved facility.	Nothing

Ambulance - continued on next page

Benefit Description	You pay
Ambulance (cont.)	**High Option**
Note: Air ambulance services for non-emergency hospital to hospital transfers must be approved through precertification. Benefits will be limited to $50,000 per occurrence if a non-network provider is used. Note: Non-network providers may also bill you for any charges that exceed the maximum amount.	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.
- 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?

An accidental bodily injury or other medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity that the absence of immediate medical attention could be reasonably expected to: place the person's health in significant jeopardy; result in serious impairment to a bodily function; result in serious dysfunction of any bodily organ or part; result in inadequately controlled pain; or with respect to a pregnant woman who is having contractions: 1) believe that there is inadequate time to effect a safe transfer to another hospital; or 2) believe that transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

What to do in case of emergency:

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

Emergencies at network hospitals within our service area

If possible, when an unexpected condition arises, call your physician – unless you believe any delay would be harmful. This applies even if it's after office hours. Your 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.

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 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 Open Access POS as soon as possible for precertification of the case

If you need additional care after an emergency condition is stabilized, precertification is required.

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 visit $40 per specialty care 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 physician. Note: We will only apply the emergency room copay as long as you are not admitted as inpatient to the hospital.	$200 per visit; if visit results in an inpatient admission, you pay a $250 per day copay for a maximum of 4 days per admission
Not covered: • *Elective 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*
Emergency outside our service area	**High Option**
• Emergency care at a doctor's office	$20 per primary care visit $40 per specialty care 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 network physician. Note: We will only apply the emergency room copay as long as you are not admitted as inpatient to the hospital.	$200 per visit; if visit results in an inpatient admission, you pay a $250 per day copay for a maximum of 4 days per admission
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*

Benefit Description	You pay
Ambulance	**High Option**
Medically necessary ambulance services when one or more of the following criteria are met: • You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation. • For ground ambulance, you are taken: - From your home, the scene of an accident or medical emergency to a hospital; - Between hospitals, including when we require you to move from a non-network hospital to a network hospital; or - Between a hospital and a skilled nursing facility or other approved facility. Note: All scheduled ground ambulance services for non-emergency transfers, except transfers from one acute facility to another, must be approved through precertification. Benefits will be limited to $50,000 per occurrence if a non-network provider is used • For air and water ambulance, you are taken: - From the scene of an accident or medical emergency to a hospital; - Between hospitals, including when we require you to move from a non-network hospital to a network hospital; or - Between a hospital and an approved facility. Note: Air ambulance services for non-emergency hospital to hospital transfers must be approved through precertification. Benefits will be limited to $50,000 per occurrence if a non-network provider is used. Note: Non-network providers may also bill you for any charges that exceed the Plan's maximum allowed amount.	Nothing

Section 5(e). Mental health and substance misuse disorder 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.
- Plan physicians must provide or arrange your care.
- There is a calendar year deductible for covered out-of-network services. The deductible is $2,000 for Self Only, $2,000 per person for Self Plus One and $6,000 for Self and Family enrollment.
- 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.

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, neuropsychologists, licensed clinical social workers, licensed professional counselors, or licensed 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 • Medication evaluation and management (pharmacotherapy) • Treatment and counseling • Diagnosis and treatment of alcoholism and drug misuse, including detoxification, treatment and counseling	Network: $20 per office visit 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 POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
• Individual and group psychotherapy for the treatment of smoking cessation	Nothing
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	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge

Benefit Description	You pay
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	Network: $250 copay per day up to a maximum of 4 days per admission POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge
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) or facility-based intensive outpatient treatment (IOP)	Network: Nothing POS Non-Network: After satisfying the annual deductible, 30% coinsurance and any difference between our payment and the billed charge

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 54.
- 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.
- Federal law prevents the pharmacy from accepting unused medications.
- 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, by mail or from our Specialty Pharmacy. When using a plan pharmacy you have two levels to choose from. Level 1 pharmacies will have lower copayments and Level 2 pharmacies will have higher copayments. Call us at 844-423-9988 or visit our website at www.bcbsga.com/federal/ga for information on how to obtain a listing of the Level 1 and Level 2 pharmacies.
- **We use a four-tier formulary**. Drugs are prescribed by Plan doctors and dispensed in accordance with Blue Open Access POS's drug formulary. The Essential prescription drug list is a list of pharmaceutical products, developed in consultation with physicians and pharmacists, approved for their quality and cost effectiveness. The covered prescription drug list is subject to periodic review and amendment. Except as otherwise stated, certain drugs may not be covered if they are not on the Essential prescription drug list. To obtain our formulary, you may check the Blue Open Access POS's website at www.bcbsga.com/federal/ga or call Client Services at 844-423-9988. 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.
- **A generic equivalent will be dispensed if it is available.** Prescription drugs will always be dispensed as ordered by your physician. When you request Tier 2 or Tier 3 drugs while Tier 1 drugs are available, you will be responsible for the difference in cost between Tier 1 and the applicable Tier copayment, in addition to the Tier one copayment. If a Tier 1 drug is not available, or your physician writes "Dispense as Written" or "Do not Substitute" on your prescription, you will only be required to pay the applicable Tier 2 or Tier 3 copayment.
- **These are the dispensing limitations.** Prescription drugs prescribed by Plan doctors and obtained at Plan pharmacies will be dispensed for up to a 30-day supply for retail pharmacies; 90-day supply from the mail order program or 30-day supply for the Specialty Pharmacy. 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.
- **The Specialty Pharmacy Program**. The Specialty Pharmacy network is available to members who use specialty drugs. "Specialty drugs" are prescription legend drugs that typically need close supervision and checking of their effect on the patient by a medical professional. They often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

  Specialty pharmacies have dedicated patient care coordinators to help you manage your condition and offer toll-free twenty-four hour access to nurses and registered pharmacists to answer questions regarding your medications.

You or your physician can order your specialty drugs directly from the Specialty Pharmacy. Simply call 1-800-870-6419. If you or your physician orders your specialty drugs from the Specialty Pharmacy, you will be assigned a patient care coordinator who will work with you and your physician to obtain prior authorization and to coordinate the shipping of your specialty drugs directly to you or your physician's office. Your patient care coordinator will also contact you directly when it is time to refill your specialty drug prescription.

- **When you do have to file a claim.** See instructions for filing claims in Section 7.

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, through our mail order program or the Specialty Pharmacy: • Prescription legend drugs • Specialty drugs • Injectable insulin and syringes used for administration of insulin • Certain supplies and equipment obtained by Mail Order or from a Network Pharmacy (such as those for diabetes and asthma) • Injectables • Compound drugs when a commercially available dosage form is not available **Note: Specialty drugs must be obtained through the Specialty Pharmacy.** You cannot obtain specialty drugs from a retail pharmacy unless we have granted an exception. **Note:** When a 90-day supply of drugs is obtained from a retail pharmacy the mail order copayments will apply.	**Level 1 Retail Pharmacy (up to a 30-day supply)** Tier 1 - $5 Tier 2 - $60 Tier 3 - $100 **Level 2 Retail Pharmacy (up to a 30-day supply)** Tier 1 - $15 Tier 2 - $70 Tier 3 - $110 Tier 4 - 25% of our allowance up to a maximum out-of-pocket of $250 per prescription order for a 30-day supply **Mail order (up to a 90-day supply)** Tier 1 - $10 Tier 2 - $150 Tier 3 - $250
• FDA approved drugs for the treatment of tobacco use Note: This includes prescription and physician prescribed over-the-counter medications.	Nothing
• Women's contraceptive drugs and devices Note: The morning after pill when prescribed by a physician and purchased at a Plan pharmacy	Nothing
Preventive care medications Medications to promote better health as recommended by ACA. The following drugs and supplements are covered without cost-share, even if over-the-counter, when prescribed by a health care professional and filled at a Plan pharmacy. • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 0-1 year • Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older • Pre-natal vitamins for pregnant women	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 Note: To receive this benefit, a prescription from a doctor must be presented to pharmacy.	Nothing
Not covered: • *Charges for the administration of any drug* • *Any drug that is primarily for weight loss (except when authorized by the Plan doctor through the prior approval process for treatment of morbid obesity)* • *Drugs in quantities that exceed the limits established by the Plan, or which exceed any age limits established by Us* • *Fertility drugs* • *Treatment of Onychomycosis (toenail fungus)* • *Refills of lost or stolen medications* • *Over-the-counter drugs not shown as covered*	*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.
- There is a calendar year deductible for covered out-of-network services. The deductible is $2,000 for Self Only, $2,000 per person for Self Plus One and $6,000 for Self and Family enrollment.
- 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. See 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 work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an injury under this Plan, unless the chewing or biting results from a medical or mental condition. Treatment must begin within 12 months of the injury, or as soon after that as possible to be a covered service under this Plan.	Network: Cost-share is based upon place of service. See specific benefit descriptions in Sections 5(a), 5(b) and 5(c).
Dental benefits	**High Option**
We have no other dental benefits.	*All charges*

Section 5(h). Wellness and Other 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) 535-8291.
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.bcbsga.com, to receive customized health information.

Feature - continued on next page

Feature	Description
Feature (cont.)	**High Option**
Disease management	Blue Open Access POS is committed to helping you and your family stay well. We created a Health Promotion and Disease Management Program to encourage awareness, healthy habits and regular doctor visits. To obtain information about these programs please visit our website at www.bcbsga.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 network providers or approved by Us, will be considered a non-network services under Blue Open Access POS. Under this option, you may choose to obtain covered health services from non-network providers. When you obtain covered medical services from a non-network provider, you will be responsible for the deductible, copayment, coinsurance, and any difference between the actual charge and the Plan's payment. This option applies to all covered services except the following:

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

Deductible

When you utilize this option you must meet the calendar year deductible of $2,000 for Self Only or $2,000 per person for Self Plus One or $6,000 for Self and Family before we begin paying for covered services.

Coinsurance

Once you have met the calendar year deductible, you owe 30% coinsurance for all covered 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 services. After your deductible and coinsurance total $8,000 for Self Only or $8,000 per person for Self Plus One or $16,000 for Self and Family enrollment for covered services, we will reimburse 100% of our maximum allowable charge and will no longer apply coinsurance for the remainder of the year. Please note that you will still be responsible for the difference between the actual charge and our payment.

What is covered

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

Emergency services

When you experience a sudden or an unexpected onset of a condition or injury you should call 911 or go to the nearest emergency facility. In this instance your out-of-pocket expense will be the same as in-network benefits. See Section 5(d) *Emergency services* for more details.

Prior approval and precertification

See Section 3 *How you get care* for details on prior approval and precertification.

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

You can receive negotiated savings on selected health and wellness services and programs simply by being an eligible Blue Open Access POS member. To obtain information about these programs please call us at 844-423-9988 or visit our website at www.bcbsga.com. Services available through the discount program include but are not limited to:

- Puritan's Pride – discounts on various vitamins, minerals and supplements
- LivingFree – discount on smoking cessation classes
- LivingEasy – discounts on stress management programs
- LivingLean – discounts on weight-loss programs
- LifeMart – deals on beauty/skin care, diet plans, fitness clubs, spas and more
- Safebeginnings – discounts on baby-proofing products
- HelpCare Plus – Senior Care Services with access to a pharmacy discount card
- EyeMed – discounts on glasses and accessories
- HearPO – discounts on hearing aids
- TruVision – preferred pricing on LASIK eye surgery
- VPI – discounts on pet insurance
- Global Fit – discounts on gym memberships, fitness equipment, coaching and more

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:

- 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 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 844-423-9988.

How to file a claim:

- You can obtain claim forms by calling Client Services at 844-423-9988. 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 Open Access POS
P. O. Box 105370
Atlanta, GA 30348-5370

Prescription drugs

Major chains and independent pharmacies belong to your pharmacy network. At these pharmacies, if you show your Blue Open Access 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 Open Access 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 Open Access POS service area.

You can obtain a Prescription Drug Claim Form by calling Client Services at 844-423-9988.

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: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

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, a health care professional with knowledge of your medical condition will be permitted 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 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.bcbsga.com/federal/ga/.

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 Open Access POS Appeals, P. O. Box 54159, Los Angeles, CA 90054 or calling 844-423-9988.

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 will not take in account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

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 Open Access POS, Attention: Appeals, P. O. Box 54159, Los Angeles, CA 90054; 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. In the case of a post-service claim, we have 30 days from the date we receive your request to:

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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.

If you do not agree with our decision, you may ask OPM to review it.

3

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 844-423-9988. 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 our website at www.bcbsga.com/.

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.
- Reimbursement to us out of your recoveries shall take first priority (before any of the rights of any other parties are honored). Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine. Our right of reimbursement is fully enforceable regardless of whether you are "made whole" (you are fully compensated for the full amount of damages claimed). We will not reduce our share of any recovery unless we agree in writing to a reduction, because (1) you do not receive the full amount of damages that you claimed, or (2) 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, or by phone 877-888-3337, (TTY 877-889-5680), 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 844-423-9988 or see our website at www.bcbsga.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.

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Blue Open Access POS

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	$2,000 Self only/$2,000 per person for Self Plus One/ $6,000 Self and Family	$2,000 Self only/$2,000 per person for Self Plus One/ $6,000 Self and Family
Out of Pocket Maximum	$8,000 Self Only/$8,000 per person for Self Plus One/ $16,000 Self and Family	$8,000 Self Only/$8,000 per person for Self Plus One/ $16,000 Self and Family
Primary Care Physician	$20	$20
Specialist	$40	$40
Inpatient Hospital	$250 per day x 4 days	$250 per day x 4 days
Outpatient Hospital	$300 per surgical admission or 20% of our allowance per non-surgical admission	$300 per surgical admission or 20% of our allowance per non-surgical admission
Rx	Level 1 Retail Tier 1 - $5, Tier 2 - $60, Tier 3 - $100 Level 2 Retail Tier 1 - $15, Tier 2 - $70, Tier 3 - $110 Tier 4 – Specialty (30 day supply) 25% up to a $250 maximum	Level 1 Retail Tier 1 - $5, Tier 2 - $60, Tier 3 - $100 Level 2 Retail Tier 1 - $15, Tier 2 - $70, Tier 3 - $110 Tier 4 – Specialty (30 day supply) 25% up to a $250 maximum
Rx – Mail Order (90 day supply)	Tier 1 - $10 Tier 2 - $150 Tier 3 -250	Tier 1 - $10 Tier 2 - $150 Tier 3 -250

- **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.

Section 10. Definitions of terms we use in this brochure

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 21.

Copayment

A fixed amount of money you pay when you receive covered services. See page 21.

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 21.

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.

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 21.

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 Open Access 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 Open Access 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 Open Access POS network.

Non-network Provider

A provider who has not entered into a contractual agreement with us for Blue Open Access 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.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

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.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

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 844-423-9988. 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 Open Access 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 four 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.

Fourth, the **Federal Employees' Group Life Insurance Program (FEGLI)** can help protect your family from burdensome funeral costs and the unexpected loss of your income.

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 $2,600 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, (TTY, 1-866-353-8058), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 866-353-8058.

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 but it may be limited. 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. Long term care can be received in your home, in a nursing home, in an assisted living facility or in adult day care. You must apply, answer health questions (called underwriting) and be approved for enrollment. Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Your qualified relatives can apply even if you do not. 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.

The Federal Employees' Group Life Insurance Program - *FEGLI*

Peace of Mind for You and Your Family

The Federal Employees' Group Life Insurance Program (FEGLI) can help protect your family from burdensome funeral costs and the unexpected loss of your income. You can get life insurance coverage starting at one year's salary to more than six times your salary and many options in between. You can also get coverage on the lives of your spouse and unmarried dependent children under age 22. You can continue your coverage into retirement if you meet certain requirements. For more information, visit www.opm.gov/life.

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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 Open Access POS - 2018

- **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 Blue Open Access POS the deductible is $2,000 for Self Only, $2,000 per person for Self Plus One and $6,000 for Self and Family enrollment.

Benefits	You pay	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	26
Lab, X-ray and other diagnostic tests	Network: Nothing POS Non-network: After satisfying the annual deductible, 30% coinsurance	27
CT Scans, MRI, MRA, PET, nuclear cardiology imaging studies, and non-maternity related ultrasounds	Network: 20% of our allowance per test POS Non-network: After satisfying the annual deductible, 30% coinsurance	27
Services provided by a hospital:		
• Inpatient	Network: $250 copay per day for a maximum of 4 days POS Non-network: After satisfying the annual deductible, 30% coinsurance	44
• Outpatient	Network: $300 per visit (Facility copay only applies when surgical procedure is performed.) 20% of our allowance for non-surgical visits POS Non-network: After satisfying the annual deductible, 30% coinsurance	45
Emergency Benefits • In-area or out-of-area	$200 per emergency room visit	49
Mental health and substance misuse disorder treatment:	Regular cost-sharing	51
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.	Level 1 / Level 2 Tier 1: $5 / $15 Tier 2: $60 / $70 Tier 3: $100 / $110 Tier 4: 25% of our allowance up to a maximum of $250	54

Benefits	You pay	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; $10 Tier 2: $150 Tier 3: $250	54
Dental care: Accidental injury only	Copay or coinsurance is based on place of service	56
Vision care: • Routine eye exam or refraction (one per calendar year)	Network: $20 per visit to your PCP or $40 per visit to a Specialist POS Non-network: After satisfying the annual deductible, 30% coinsurance	32
Wellness and Other Special features: Flexible benefits option; Reciprocity; Centers of Excellence; Disease Management		57
Protection against catastrophic costs (out-of-pocket maximum)**:**	Network: $4,000 Self Only or $4,000 per person for Self Plus One or $8,000 Self and Family per year. POS Non-network: $8,000 Self only or $8,000 per person for Self Plus One or $16,000 Self and Family per year.	21

2018 Rate Information

For 2018 FEHB plan premium information, please see:

https://www.opm.gov/healthcare-insurance/tribal-employers/benefits-premiums/ or contact your tribal employer's Human Resources department.