Blue Cross® and Blue Shield® Service Benefit Plan

http://www.fepblue.org

2014

A fee-for-service plan (standard and basic option) with a preferred provider organization

IMPORTANT:

- Rates: Back Cover
- Changes for 2014: Page 15
- Summary of benefits: Page 153

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 9 for details.

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

Who may enroll in this Plan: All Federal employees, Tribal employees, and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program

Enrollment codes for this Plan:

104 Standard Option - Self Only
105 Standard Option - Self and Family
111 Basic Option - Self Only
112 Basic Option - Self and Family

The Case Management programs for this Plan are accredited through URAC or NCQA, or through Health Plan accreditation from NCQA.

See the 2014 FEHB Guide for more information on accreditation.

Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Healthcare and Insurance
www.opm.gov/healthcare-insurance

RI 71-005

Important Notice from the Blue Cross and Blue Shield Service Benefit Plan About Our Prescription Drug Coverage and Medicare

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

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

Remember: If you are an annuitant and you 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 premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

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

Table of Contents

Introduction 5

Plain Language 5

Stop Health Care Fraud! 5

Preventing Medical Mistakes 6

FEHB Facts 9

Coverage information 9
- No pre-existing condition limitation 9
- Minimum essential coverage (MEC) 9
- Minimum value standard 9
- Where you can get information about enrolling in the FEHB Program 9
- Types of coverage available for you and your family 9
- Family member coverage 10
- Children's Equity Act 10
- When benefits and premiums start 11
- When you retire 11

When you lose benefits 11
- When FEHB coverage ends 11
- Upon divorce 11
- Temporary Continuation of Coverage (TCC) 12
- Converting to individual coverage 12
- Health Insurance Market Place 12
- Getting a Certificate of Group Health Plan Coverage 12

Section 1. How this Plan works 13

General features of our Standard and Basic Options 13

We have a Preferred Provider Organization (PPO) 13

How we pay professional and facility providers 13

Your rights 14

Your medical and claims records are confidential 14

Section 2. Changes for 2014 15

Section 3. How you receive benefits 18

Identification cards 18

Where you get covered care 18
- Covered professional providers 18
- Covered facility providers 19

What you must do to get covered care 21
- Transitional care 22
- If you are hospitalized when your enrollment begins 22

You need prior Plan approval for certain services 22
- Inpatient hospital admission 22
- Other services 23

How to request precertification for an admission or get prior approval for Other services 24
- Non-urgent care claims 25
- Urgent care claims 25
- Concurrent care claims 25
- Emergency inpatient admission 25
- Maternity care 26
- If your hospital stay needs to be extended 26
- If your treatment needs to be extended 26

If you disagree with our pre-service claim decision 26
- To reconsider a non-urgent care claim 26
- To reconsider an urgent care claim 26
- To file an appeal with OPM 26

Section 4. Your costs for covered services 27
Cost-sharing 27
Copayment 27
Deductible 27
Coinsurance 27
If your provider routinely waives your cost 28
Waivers 28
Differences between our allowance and the bill 28
Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments 31
Carryover 32
If we overpay you 32
When Government facilities bill us 32

Section 5. Benefits
Standard and Basic Option Benefits 33
Non-FEHB benefits available to Plan members 123

Section 6. General exclusions – services, drugs, and supplies we do not cover 125

Section 7. Filing a claim for covered services 127

Section 8. The disputed claims process 130

Section 9. Coordinating benefits with Medicare and other coverage 132
When you have other health coverage 132
- TRICARE and CHAMPVA 132
- Workers' Compensation 133
- Medicaid 133

When other Government agencies are responsible for your care 133
When others are responsible for injuries 133
When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) 134
Clinical trials 134
When you have Medicare 135
- What is Medicare? 135
- Should I enroll in Medicare? 135
- The Original Medicare Plan (Part A or Part B) 136
- Tell us about your Medicare coverage 137
- Private contract with your physician 137
- Medicare Advantage (Part C) 137
- Medicare prescription drug coverage (Part D) 137
- Medicare prescription drug coverage (Part B) 137

When you are age 65 or over and do not have Medicare 139
When you have the Original Medicare Plan (Part A, Part B, or both) 140

Section 10. Definitions of terms we use in this brochure 141

Section 11. Other Federal Programs 150
The Federal Flexible Spending Account Program – *FSAFEDS* 150
The Federal Employees Dental and Vision Insurance Program – *FEDVIP* 151
The Federal Long Term Care Insurance Program – *FLTCIP* 151

Index 152

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2014 153

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2014 155

2014 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan 156

Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan** under our contract (CS 1039) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan in their individual localities. For customer service assistance, visit our Web site, www.fepblue.org, or contact your Local Plan at the telephone number appearing on the back of your ID card.

The Blue Cross and Blue Shield Association is the Carrier of the Plan. The address for the Blue Cross and Blue Shield Service Benefit Plan administrative office is:

Blue Cross and Blue Shield Service Benefit Plan
1310 G Street, NW, Suite 900
Washington, DC 20005

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2014, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2014, and changes are summarized on pages 15-17. Rates are shown on the back cover 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) Web site 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 meets 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 the Blue Cross and Blue Shield Service Benefit Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- 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 1-800-FEP-8440 (1-800-337-8440) and explain the situation.
  - If we do not resolve the issue:

CALL — THE HEALTH CARE FRAUD HOTLINE
1-877-499-7295
OR go to www.opm.gov/oig
You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

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

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

2. **Keep and bring a list of all the medicines you take.**
   - Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
   - Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
   - Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
   - Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
   - Read the label and patient package insert when you get your medicine, including all warnings and instructions.
   - Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
   - Contact your doctor or pharmacist if you have any questions.
3. **Get the results of any test or procedure.**
   - Ask when and how you will get the results of tests or procedures.
   - Do not assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
   - Call your doctor and ask for your results.
   - Ask what the results mean for your care.
4. **Talk to your doctor about which hospital is best for your health needs.**
   - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
   - Be sure you understand the instructions you get about follow-up care when you leave the hospital.
5. **Make sure you understand what will happen if you need surgery.**
   - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
   - Ask your doctor, "Who will manage my care when I am in the hospital?"
   - Ask your surgeon:
     - "Exactly what will you be doing?"
     - "About how long will it take?"
     - "What will happen after surgery?"
     - "How can I expect to feel during recovery?"
   - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct never events, if you use Service Benefit Plan Preferred or Member hospitals. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

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

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

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) Web site 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**

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 meets the minimum value standard for the benefits the Plan provides.

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

See www.opm.gov/healthcare-insurance/healthcare for enrollment information as well as:

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

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

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

We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

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

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health 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 Web site 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 your spouse by valid common-law marriage if you reside in a state that recognizes common-law marriages) and children as described in the chart below.

Children	Coverage
Natural, 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.

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

- **Children's Equity Act**

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective on 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 2014 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 2013 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 benefits coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

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

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn age 26, regardless of marital status, etc.

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

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

We also want to inform you that the Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules.

- **Converting to individual coverage**

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

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

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

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

- **Health Insurance Market Place**

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 Web site provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

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

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

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

Section 1. How this Plan works

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

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

General features of our Standard and Basic Options

We have a Preferred Provider Organization (PPO)

Our fee-for-service plan offers services through a PPO. This means that certain hospitals and other health care providers are "Preferred providers." When you use our PPO (Preferred) providers, you will receive covered services at a reduced cost. Your Local Plan (or, for retail pharmacies, CVS Caremark) is solely responsible for the selection of PPO providers in your area. Contact your Local Plan for the names of PPO (Preferred) providers and to verify their continued participation. You can also go to our Web page, www.fepblue.org, and select "Provider Directory" to use our National Doctor & Hospital Finder℠. You can reach our Web page through the FEHB Web site, www.opm.gov/healthcare-insurance.

Under Standard Option, PPO (Preferred) benefits apply only when you use a PPO (Preferred) provider. PPO networks may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas. If no PPO (Preferred) provider is available, or you do not use a PPO (Preferred) provider, non-PPO (Non-preferred) benefits apply.

Under Basic Option, you must use Preferred providers in order to receive benefits. See page 21 for the exceptions to this requirement.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

How we pay professional and facility providers

We pay benefits when we receive a claim for covered services. Each Local Plan contracts with hospitals and other health care facilities, physicians, and other health care professionals in its service area, and is responsible for processing and paying claims for services you receive within that area. Many, but not all, of these contracted providers are in our PPO (Preferred) network.

- **PPO providers.** PPO (Preferred) providers have agreed to accept a specific negotiated amount as payment in full for covered services provided to you. **We refer to PPO facility and professional providers as "Preferred."** They will generally bill the Local Plan directly, who will then pay them directly. You do not file a claim. Your out-of-pocket costs are generally less when you receive covered services from Preferred providers, and are limited to your coinsurance or copayments (and, under **Standard Option** only, the applicable deductible).
- **Participating providers.** Some Local Plans also contract with other providers that are not in our Preferred network. **If they are professionals, we refer to them as "Participating" providers. If they are facilities, we refer to them as "Member" facilities.** They have agreed to accept a different negotiated amount than our Preferred providers as payment in full. They will also generally file your claims for you. They have agreed not to bill you for more than your applicable deductible, and coinsurance or copayments, for covered services. We pay them directly, but at our Non-preferred benefit levels. Your out-of-pocket costs will be greater than if you use Preferred providers.

  Note: Not all areas have Participating providers and/or Member facilities. To verify the status of a provider, please contact the Local Plan where the services will be performed.

- **Non-participating providers.** Providers who are not Preferred or Participating providers do not have contracts with us, and may or may not accept our allowance. **We refer to them as "Non-participating providers" generally, although if they are facilities we refer to them as "Non-member facilities."** When you use Non-participating providers, you may have to file your claims with us. We will then pay our benefits to you, and you must pay the provider.

  You must pay any difference between the amount Non-participating providers charge and our allowance (except in certain circumstances – see pages 145-147). In addition, you must pay any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for noncovered services. **Important: Under Standard Option, your out-of-pocket costs may be substantially higher when you use Non-participating providers than when you use Preferred or Participating providers.** Under Basic Option, you must use Preferred providers to receive benefits. See page 21 for the exceptions to this requirement.

  Note: In Local Plan areas, Preferred providers and Participating providers who contract with us will accept 100% of the Plan allowance as payment in full for covered services. As a result, you are only responsible for applicable coinsurance or copayments (and, under **Standard Option** only, the applicable deductible), for covered services, and any charges for noncovered services.

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Care management, including medical practice guidelines;
- Disease management programs; and
- How we determine if procedures are experimental or investigational.

If you want more information about us, call or write to us. Our telephone number and address are shown on the back of your Service Benefit Plan ID card. You may also visit our Web site at www.fepblue.org.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. ***Note:*** As part of our administration of this contract, we may disclose your medical and claims information (including your prescription drug utilization) to any treating physicians or dispensing pharmacies. You may view our Notice of Privacy Practice for more information about how we may use and disclose member information by visiting our Web site at www.fepblue.org.

Section 2. Changes for 2014

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

Changes to our Standard Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. (See page 156.)
- For Self and Family contracts, your catastrophic out-of-pocket maximum is now $6,000 per year when you use Preferred providers and $8,000 per year when you use a combination of Preferred and Non-preferred providers. Previously, the out-of-pocket maximum was $5,000 for Preferred provider services and $7,000 for both Preferred and Non-preferred providers. (See page 31.)
- Your calendar year deductible is now included in the out-of-pocket catastrophic protection maximum, in addition to coinsurance and copayments. Previously, the out-of-pocket maximum did not include your calendar year deductible. (See page 31.)
- We now provide benefits for two hours of home nursing care per day, up to a maximum of 50 visits per calendar year. Previously, benefits were only available for up to 25 visits per calendar year. (See page 59.)
- We modified the list of generic drug replacements included in our Standard Option Generic Incentive Program. (See page 101.)
- Your copayment for Tier 2 preferred brand-name drugs purchased through the Mail Service Prescription Drug Program is now $80 per prescription for up to a 90-day supply. Previously, you paid $70 for Tier 2 preferred brand-name drugs. (See page 107.)
- Your copayment for Tier 3 non-preferred brand-name drugs purchased through the Mail Service Prescription Drug Program is now $105 per prescription for up to a 90-day supply. Previously, you paid $95 for Tier 3 non-preferred brand-name drugs. (See page 107.)
- We now have two Tiers of specialty drugs: Tier 4 includes preferred specialty drugs and Tier 5 includes non-preferred specialty drugs. Previously, all specialty drugs were included in Tier 4. (See page 99.)
- You may fill new prescriptions of Tier 4 or Tier 5 specialty drugs at a Preferred retail pharmacy or through the Specialty Drug Pharmacy Program. You must use the Specialty Drug Pharmacy Program for any refills of the same specialty drug. We will cover supplies of up to 30 days for your first three fills of the same Tier 4 or Tier 5 prescription. You may receive supplies of up to 90 days beginning with your fourth fill. Previously, you could use a retail pharmacy or our specialty pharmacy to purchase 90-day supplies of new or continuing specialty drugs. (See pages 105 and 108.)
- Your copayment for Tier 4 preferred specialty drugs dispensed by the Specialty Drug Pharmacy Program is now $35 for up to a 30-day supply, and $95 for up to a 90-day supply. Previously, your copayment for Tier 4 specialty drugs obtained through the Specialty Drug Pharmacy Program was $80 for each 90-day supply. (See page 108.)
- You pay 30% of the Plan allowance for Tier 5 non-preferred specialty drugs dispensed by a Preferred retail pharmacy. Previously, there were no Tier 5 non-preferred specialty drugs. (See page 105.)
- Your copayment for Tier 5 non-preferred specialty drugs dispensed by the Specialty Drug Pharmacy Program is $55 for up to a 30-day supply, and $155 for up to a 90-day supply. Previously, there were no Tier 5 non-preferred specialty drugs. (See page 108.)

Changes to our Basic Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. (See page 156.)
- For Self Only contracts, the catastrophic out-of-pocket maximum for coinsurance and copayments is now $5,500 per year when you use Preferred providers. For Self and Family contracts, the maximum is now $7,000 per year when you use Preferred providers. Previously, the catastrophic out-of-pocket maximum was $5,000 for Preferred provider services for both Self Only and Self and Family contracts. (See page 31.)
- The coinsurance amount you pay for non-preferred brand-name drugs purchased at Preferred retail pharmacies now counts toward your annual catastrophic protection out-of-pocket maximum. Previously, this amount was not included in your out-of-pocket maximum. (See page 31.)
- Your copayment for neurological testing performed by a Preferred professional provider is now $40. Previously, you had no copayment for these services. (See page 39.)
- Your copayment for diagnostic tests such as EEGs, ultrasounds, and X-rays performed by a Preferred professional provider is now $40. Previously, your copayment for EEGs, ultrasounds, and X-rays was $25. (See page 39.)

- Your copayment for the diagnostic studies and radiological services listed on page 40 in Section 5(a) is now $100 when performed by a Preferred professional provider. Previously, your copayment for these services was $75. (See page 40.)
- Your copayment for the outpatient **diagnostic testing and treatment services** listed on page 82 in Section 5(c) is now $150 per day per facility, when you receive those services at a Preferred, Member, or Non-member facility. Previously, your copayment for these services was $100 per day per facility. (See page 82.)
- Your copayment for outpatient **diagnostic testing services** such as EEGs, ultrasounds, and X-rays is now $40 per day per facility, when you receive those services at a Preferred, Member, or Non-member facility. Previously, your copayment for these services was $25 per day per facility. (See page 82.)
- We now provide benefits for up to 10 visits per year for acupuncture performed by Preferred providers acting within the scope of their license or certification in the state where the services are provided. Previously, Basic Option benefits were available for acupuncture only when provided by a physician. (See page 60.)
- Your copayment for surgical procedures performed outside of the office setting is now $200 per performing surgeon. Previously, your copayment for surgical procedures performed in any setting was $150 per performing surgeon. (See pages 63-73.)
- Your copayment for an inpatient admission to a Preferred facility is $175 per day up to a maximum of $875 for unlimited days. Previously, your copayment for an inpatient admission was $150 per day up to a maximum of $750 for unlimited days. (See pages 78-79, and 96.)
- Your copayment for a maternity inpatient admission to a Preferred facility is $175. Previously, your copayment for a maternity inpatient admission was $150. (See pages 46 and 79.)
- For Tier 1 (generic), Tier 2 (preferred brand-name), and Tier 3 (non-preferred brand-name) prescriptions obtained from a Preferred retail pharmacy, you may purchase up to a 30-day supply per copayment. Previously, you were limited to a 34-day supply per copayment. (See pages 100 and 105.)
- Your copayment for Tier 2 preferred brand-name drugs purchased at a Preferred retail pharmacy is now $45 per prescription for up to a 30-day supply. Previously, you paid $40 for Tier 2 preferred brand-name drugs. (See page 105.)
- Your minimum copayment for Tier 3 non-preferred brand-name drugs purchased at a Preferred retail pharmacy is now $55 for each purchase of up to a 30-day supply. Previously, you paid a minimum of $50 for Tier 3 non-preferred brand-name drugs. (See page 105.)
- We now have two Tiers of specialty drugs: Tier 4 includes preferred specialty drugs and Tier 5 includes non-preferred specialty drugs. Previously, all specialty drugs were included in Tier 4. (See page 99.)
- You may fill new prescriptions of Tier 4 or Tier 5 specialty drugs at a Preferred retail pharmacy or through the Specialty Drug Pharmacy Program. You must use the Specialty Drug Pharmacy Program for any refills of the same specialty drug. We will cover supplies of up to 30 days for your first three fills of the same Tier 4 or Tier 5 prescription. You may receive supplies of up to 90 days beginning with your fourth fill. Previously, you could use a retail pharmacy or our specialty pharmacy to purchase 90-day supplies of new or continuing specialty drugs. (See pages 105 and 108.)
- Your copayment for Tier 4 preferred specialty drugs dispensed by a Preferred retail pharmacy is now $60, and benefits are limited to one purchase of up to a 30-day supply for each prescription filled. Previously, your copayment for Tier 4 specialty drugs purchased at a Preferred retail pharmacy was $50 for up to a 34-day supply or $150 for up to a 90-day supply; you could also receive refills from a Preferred retail pharmacy. (See page 105.)
- Your copayment for Tier 5 non-preferred specialty drugs dispensed by a Preferred retail pharmacy is $80, and benefits are limited to one purchase of up to a 30-day supply for each prescription filled. Previously, there were no Tier 5 non-preferred specialty drugs. (See page 105.)
- Your copayment for Tier 4 preferred specialty drugs dispensed through the Specialty Drug Pharmacy Program is now $50 for up to a 30-day supply, and $140 for up to a 90-day supply. Previously, your copayment for Tier 4 specialty drugs obtained through the Specialty Drug Pharmacy Program was $40 for up to a 34-day supply or $120 for a 90-day supply. (See page 108.)
- Your copayment for Tier 5 non-preferred specialty drugs dispensed through the Specialty Drug Pharmacy Program is $70 for up to a 30-day supply, and $195 for up to a 90-day supply. Previously, there were no Tier 5 non-preferred specialty drugs. (See page 108.)

Changes to both our Standard and Basic Options

- Subject to the criteria appearing on page 18, we now cover any licensed medical practitioner for covered services performed within the scope of that license, as required by Section 2706(a) of the Public Health Service Act (PHSA). Previously, benefits for certain medical practitioners were limited to services performed in Medically Underserved Areas (MUAs).
- You are entitled to receive a $40 health account to be used for qualified medical expenses when you complete a Blue Health Assessment (BHA) questionnaire. You are also entitled to receive up to an additional $35 for achieving goals related to improving exercise and nutrition, reducing stress levels, managing your weight, and improving emotional health. Previously, you were entitled to receive a $35 health account when you completed a BHA and up to an additional $15 for completing up to three (3) online coaching sessions. [See Section 5(h).]
- We now provide preventive care benefits for testing for deleterious mutations in BRCA1 and BRCA2 genes in females, age 18 and over, who have not personally been diagnosed with breast or ovarian cancer. Benefits are limited to one BRCA test per lifetime whether the test is covered under Preventive Care benefits (see page 43) or is covered under Diagnostic testing benefits (see page 40). Previously, Preventive Care benefits were not available for this service. (See page 43.)
- We now limit benefits for diagnostic BRCA testing for members with a personal history of cancer to one test per lifetime whether the test is covered under Preventive Care benefits (see page 43) or is covered under Diagnostic testing benefits (see page 40). Previously, benefits for diagnostic BRCA testing were not subject to a limit.
- We now provide benefits for wigs for hair loss due to cancer treatment, limited to a maximum of $350 for one wig per lifetime. Previously, benefits were only available for wigs for hair loss due to chemotherapy for the treatment of cancer. (See page 56.)
- Benefits for chiropractic care are no longer limited to one office visit and one set of X-rays per year. See page 37 for the benefits we provide for office visits and pages 39 and 40 for our coverage of radiological services performed by covered professional providers.
- We now provide benefits for insulin and diabetic supplies only when obtained from a retail pharmacy or, for Standard Option only, through the Mail Service Prescription Drug Program. This requirement does not apply if you have Medicare Part B as primary. Previously, insulin and diabetic supplies were also covered when obtained from physicians and other health care professionals, including medical supply companies and durable medical equipment providers. (See pages 58, 102, and 111.)
- We now provide benefits in full for Vitamin D supplements for adults, age 65 and over, as recommended under the Affordable Care Act. Previously, benefits were not available for Vitamin D supplements. (See page 104.)
- We now use an Overseas Fee Schedule as our Plan allowance for services performed overseas by professional providers that do not contract with us or with AXA Assistance. Previously, we used a customary percentage of the billed charge as our Plan allowance. (See pages 121 and 146.)
- We now consider the Medicare Part B Drug Average Sale Price (ASP) for drugs dispensed or administered by Non-participating physicians and other covered health care professionals when we determine our Plan allowance. Previously, we did not consider the Average Sale Price when determining our Plan allowance for drugs. (See page 146.)
- We no longer provide benefits for heart-lung transplants performed at Blue Distinction Centers for Transplants. Previously, benefits were available for heart-lung transplants performed at these types of facilities.

Section 3. How you receive benefits

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 will need it whenever you receive services from a covered provider, or fill a prescription through a Preferred retail 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 the Local Plan serving the area where you reside and ask them to assist you, or write to us directly at: FEP® Enrollment Services, 840 First Street, NE, Washington, DC 20065. You may also request replacement cards through our Web site, www.fepblue.org.

Where you get covered care

Under Standard Option, you can get care from any "covered professional provider" or "covered facility provider." How much we pay – and you pay – depends on the type of covered provider you use. If you use our Preferred, Participating, or Member providers, you will pay less.

Under Basic Option, you **must** use those "covered professional providers" or "covered facility providers" that are **Preferred providers** for Basic Option in order to receive benefits. Please refer to page 21 for the exceptions to this requirement. Refer to page 13 for more information about Preferred providers.

The term "primary care provider" includes family practitioners, general practitioners, medical internists, pediatricians, obstetricians/gynecologists, and physician assistants.

• Covered professional providers

We provide benefits for the services of covered professional providers (see below for definition), as required by Section 2706(a) of the Public Health Service Act (PHSA). Benefits are available for covered services provided anywhere in the United States, Puerto Rico, and the U.S. Virgin Islands. Coverage of practitioners is not determined by your state's designation as a Medically Underserved Area (MUA). As reflected in Section 5, the Plan does limit coverage for some services, in accordance with accepted standards of clinical practice regardless of the geographic area.

- **Under Standard Option,** we cover any licensed professional provider for covered services performed within the scope of that license.
- **Under Basic Option,** we cover any licensed professional provider who is **Preferred** for covered services performed within the scope of that license.

Covered professional providers are medical practitioners who perform covered services when acting within the scope of their license or certification under applicable state law and who furnish, bill, or are paid for their health care services in the normal course of business. Covered services must be provided in the state in which the practitioner is licensed or certified. Your Local Plan is responsible for determining the provider's licensing status and scope of practice.

If the state has no applicable licensing or certification requirement, the provider must meet the requirements of the Local Plan. See below for additional requirements that apply to the practitioners listed.

Physicians – Doctors of medicine (M.D.); Doctors of osteopathy (D.O.); Doctors of dental surgery (D.D.S.); Doctors of medical dentistry (D.M.D.); Doctors of podiatric medicine (D.P.M.); Doctors of optometry (O.D.); and Doctors of Chiropractic/chiropractors (D.C.).

Other Covered Health Care Professionals – Professionals such as the medical practitioners listed below, when they provide covered services *and* meet the state's applicable licensing or certification requirements; the requirements of the Local Plan; and any other requirements as specifically listed below:

- **Audiologist –** A professional who, if the state requires it, is licensed, certified, or registered as an audiologist where the services are performed.
- **Clinical Psychologist –** A psychologist who (1) is licensed or certified in the state where the services are performed; (2) has a doctoral degree in psychology (or an allied degree if, in the individual state, the academic licensing/certification requirement for clinical psychologist is met by an allied degree) or is approved by the Local Plan; and (3) has met the clinical psychological experience requirements of the individual State Licensing Board.
- **Clinical Social Worker –** A social worker who (1) has a master's or doctoral degree in social work; (2) has at least two years of clinical social work practice; and (3) if the state requires it, is licensed, certified, or registered as a social worker where the services are performed.
- **Diabetic Educator –** A professional who, if the state requires it, is licensed, certified, or registered as a diabetic educator where the services are performed.
- **Dietician –** A professional who, if the state requires it, is licensed, certified, or registered as a dietician where the services are performed.
- **Independent Laboratory –** A laboratory that is licensed under state law or, where no licensing requirement exists, that is approved by the Local Plan.
- **Lactation Consultant –** A person who is licensed as a Registered Nurse in the United States (or appropriate equivalent if providing services overseas) and is licensed or certified as a lactation consultant by a nationally recognized organization.
- **Mental Health or Substance Abuse professional –** A professional who is licensed by the state where the care is provided to provide mental health and/or substance abuse services within the scope of that license.
- **Certified Midwife –** A person who is certified by the American College of Nurse Midwives or the American Midwifery Certification Board, *and* is licensed, certified, or authorized to practice as a Certified Nurse Midwife (CNM) or Certified Midwife (CM) in the state or jurisdiction in which the services are provided.
- **Nurse Practitioner/Clinical Specialist –** A person who (1) has an active R.N. license in the United States; (2) has a baccalaureate or higher degree in nursing; and (3) if the state requires it, is licensed or certified as a nurse practitioner or clinical nurse specialist.
- **Nursing School Administered Clinic –** A clinic that (1) is licensed or certified in the state where services are performed; and (2) provides ambulatory care in an outpatient setting – primarily in rural or inner-city areas where there is a shortage of physicians. Services billed by these clinics are considered outpatient "office" services rather than facility charges.
- **Nutritionist –** A professional who, if the state requires it, is licensed, certified, or registered as a nutritionist where the services are performed.
- **Physical, Speech, and Occupational Therapist –** A professional who is licensed where the services are performed or meets the requirements of the Local Plan to provide physical, speech, or occupational therapy services.
- **Physician Assistant –** A person who is nationally certified by the National Commission on Certification of Physician Assistants in conjunction with the National Board of Medical Examiners or, if the state requires it, is licensed, certified, or registered as a physician assistant where the services are performed.

• Covered facility providers

Covered facilities include those listed below, when they meet the state's applicable licensing or certification requirements.

Hospital – An institution, or a distinct portion of an institution, that:

(1) Primarily provides diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of injured and sick persons provided or supervised by a staff of licensed doctors of medicine (M.D.) or licensed doctors of osteopathy (D.O.), for compensation from its patients, on an inpatient or outpatient basis;

(2) Continuously provides 24-hour-a-day professional registered nursing (R.N.) services; and

(3) Is not, other than incidentally, an extended care facility; a nursing home; a place for rest; an institution for exceptional children, the aged, drug addicts, or alcoholics; or a custodial or domiciliary institution having as its primary purpose the furnishing of food, shelter, training, or non-medical personal services.

Note: We consider college infirmaries to be Non-member hospitals. In addition, we may, at our discretion, recognize any institution located outside the 50 states and the District of Columbia as a Non-member hospital.

Freestanding Ambulatory Facility – A freestanding facility, such as an ambulatory surgical center, freestanding surgi-center, freestanding dialysis center, or freestanding ambulatory medical facility, that:

(1) Provides services in an outpatient setting;
(2) Contains permanent amenities and equipment primarily for the purpose of performing medical, surgical, and/or renal dialysis procedures;
(3) Provides treatment performed or supervised by doctors and/or nurses, and may include other professional services performed at the facility; and
(4) Is not, other than incidentally, an office or clinic for the private practice of a doctor or other professional.

Note: We may, at our discretion, recognize any other similar facilities, such as birthing centers, as freestanding ambulatory facilities.

Blue Distinction Centers®

Certain facilities have been selected to be Blue Distinction Centers for Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, and Complex and Rare Cancers. These facilities meet objective quality criteria established with input from expert physician panels, surgeons, and other medical professionals. Blue Distinction Centers offer comprehensive care delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise.

We cover facility costs for specialty care at designated Blue Distinction Centers at Preferred benefit levels, which means that your out-of-pocket expenses for specialty facility services are limited.

Facility care that is not part of the Blue Distinction Program is reimbursed according to the network status of the facility. In addition, some Blue Distinction Centers may use professional providers who do not participate in our provider network. Non-participating providers have no agreements with us to limit what they can bill you. This is why it's important to always request Preferred providers for your care. For more information, see pages 27-32 in Section 4, *Your costs for covered services*, or call your Local Plan at the number listed on the back of your ID card. For listings of Preferred providers in your area, go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder.

If you are considering covered bariatric surgery, cardiac procedures, knee or hip replacement, spine surgery, or inpatient treatment for a complex or rare cancer, you may want to consider receiving those services at a Blue Distinction Center. To locate a Blue Distinction Center, go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder, or call us at the customer service number listed on the back of your ID card.

Blue Distinction Centers for Transplants®

In addition to Preferred transplant facilities, you have access to Blue Distinction Centers for Transplants. Blue Distinction Centers for Transplants are selected based on their ability to meet defined clinical quality criteria that are unique for each type of transplant. We provide enhanced benefits for covered transplant services performed at these designated centers during the transplant period (see page 148 for the definition of "transplant period").

Members who choose to use a Blue Distinction Centers for Transplants facility for a covered transplant only pay the $250 per admission copayment under Standard Option, or the $175 per day copayment ($875 maximum) under Basic Option, for the transplant period. Members are not responsible for additional costs for included professional services.

Regular benefits (subject to the regular cost-sharing levels for facility and professional services) are paid for pre- and post-transplant services performed in Blue Distinction Centers for Transplants before and after the transplant period. (Regular benefit levels and cost-sharing amounts also apply to services unrelated to a covered transplant.)

Blue Distinction Centers for Transplants are available for the following types of transplants: heart; single or double lung; liver; pancreas (pancreas transplant alone, pancreas after kidney, simultaneous pancreas-kidney); and autologous or allogeneic blood or marrow stem cell (see page 75 for limitations).

Note: Certain stem cell transplants **must** be performed at a Blue Distinction Centers for Transplants facility (see pages 70-71).

All members (including those who have Medicare Part A or another group health insurance policy as their primary payor) must contact us at the customer service number listed on the back of their ID card before obtaining services. We will refer you to the designated Plan transplant coordinator for information about Blue Distinction Centers for Transplants and assistance in arranging for your transplant at a Blue Distinction Centers for Transplants facility.

Cancer Research Facility – A facility that is:

(1) A National Cooperative Cancer Study Group institution that is funded by the National Cancer Institute (NCI) and has been approved by a Cooperative Group as a blood or marrow stem cell transplant center;

(2) An NCI-designated Cancer Center; or

(3) An institution that has a peer-reviewed grant funded by the National Cancer Institute (NCI) or National Institutes of Health (NIH) to study allogeneic or autologous blood or marrow stem cell transplants.

FACT-Accredited Facility

A facility with a transplant program accredited by the Foundation for the Accreditation of Cellular Therapy (FACT). FACT-accredited cellular therapy programs meet rigorous standards. Information regarding FACT transplant programs can be obtained by contacting the transplant coordinator at the customer service number listed on the back of your ID card or by visiting www.factwebsite.org.

Other facilities specifically listed in the benefits descriptions in Section 5(c).

What you must do to get covered care

Under Standard Option, you can go to any covered provider you want, but in some circumstances, we must approve your care in advance.

Under Basic Option, you **must** use **Preferred** providers in order to receive benefits, except under the special situations listed below. In addition, we must approve certain types of care in advance. Please refer to Section 4, *Your costs for covered services*, for related benefits information.

(1) Medical emergency or accidental injury care in a hospital emergency room and related ambulance transport as described in Section 5(d), *Emergency services/accidents*;
(2) Professional care provided at Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons;
(3) Laboratory and pathology services, X-rays, and diagnostic tests billed by Non-preferred laboratories, radiologists, and outpatient facilities;
(4) Services of assistant surgeons;
(5) Special provider access situations (we encourage you to contact your Local Plan for more information in these types of situations before you receive services from a Non-preferred provider); or
(6) Care received outside the United States, Puerto Rico, and the U.S. Virgin Islands.

Unless otherwise noted in Section 5, when services of Non-preferred providers are covered in a special exception, benefits will be provided based on the Plan allowance. You are responsible for the applicable coinsurance or copayment, and may also be responsible for any difference between our allowance and the billed amount.

- **Transitional care**

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

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan, or
- lose access to your Preferred specialist because we terminate our contract with your specialist for reasons other than for cause,

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

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call us immediately. If you have not yet received your Service Benefit Plan ID card, you can contact your Local Plan at the telephone number listed in your local telephone directory. If you already have your new Service Benefit Plan ID card, call us at the number on the back of the card. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

However, 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 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

The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for *Other services* (called prior approval), are detailed in this Section. A **pre-service claim** is any claim, in whole or in part, that requires approval from us before you receive medical care or services. In other words, a pre-service claim for benefits (1) requires precertification or prior approval and (2) will result in a reduction of benefits if you do not obtain precertification or prior approval.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay, the procedure(s)/service(s) to be performed, and the number of days required to treat your condition. Unless we are misled by the information given to us, we will not change our decision on medical necessity.

In most cases, your physician or hospital will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether they have contacted us. For information about precertification of an emergency inpatient admission, please see page 25.

Warning: We will reduce our benefits for the inpatient hospital stay by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will not provide benefits for inpatient room and board or inpatient physician care; we will only pay for covered medical services and supplies that are otherwise payable on an outpatient basis.

Exceptions: You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payor for the hospital stay. (See pages 20-21 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)
- Medicare Part A is the primary payor for the hospital stay. (See pages 20-21 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)

  Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then you **do** need precertification.

  Note: Morbid obesity surgery performed during an inpatient stay (even when Medicare Part A is your primary payor) must meet the surgical requirements described on page 64 in order for benefits to be provided for the admission and surgical procedure.

• Other services

You must obtain prior approval for these services under both Standard and Basic Option:

- **Outpatient surgical services –** The surgical services listed below require prior approval when they are to be performed on an outpatient basis. This requirement applies to both the physician services and the facility services from Preferred, Participating/Member, and Non-participating/Non-member providers. You must contact us at the customer service number listed on the back of your ID card before obtaining these types of services.
  - Outpatient surgery for morbid obesity. ***Note:*** **Benefits for the surgical treatment of morbid obesity – performed on an inpatient or outpatient basis – are subject to the pre-surgical requirements listed on page 64;**
  - Outpatient surgical correction of congenital anomalies; and
  - Outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth.
- **Outpatient intensity-modulated radiation therapy (IMRT) –** Prior approval is required for all outpatient IMRT services except IMRT related to the treatment of head, neck, breast, or prostate cancer. Brain cancer is not considered a form of head or neck cancer; therefore, prior approval is required for IMRT treatment of brain cancer. Contact us at the customer service number listed on the back of your ID card before receiving outpatient IMRT for cancers which require prior approval. We will request the medical evidence we need to make our coverage determination.
- **Hospice care –** Contact us at the customer service number listed on the back of your ID card before obtaining home hospice, continuous home hospice, or inpatient hospice care services. We will request the medical evidence we need to make our coverage determination and advise you which home hospice care agencies we have approved. See page 86 for information about the exception to this requirement.
- **Organ/tissue transplants –** Contact us at the customer service number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination. We will consider whether the facility is approved for the procedure and whether you meet the facility's criteria.
- **Clinical trials for certain organ/tissue transplants –** See pages 72 and 73 for the list of conditions covered **only** in clinical trials for blood or marrow stem cell transplants. Contact us at the customer service number on the back of your ID card for information or to request prior approval before obtaining services. We will request the medical evidence we need to make our coverage determination.

  Note: For the purposes of the blood or marrow stem cell clinical trial transplants listed on pages 72 and 73, a clinical trial is a research study whose protocol has been reviewed and approved by the Institutional Review Board of the Cancer Research Facility or FACT-accredited facility (see page 21) where the procedure is to be delivered.

- **Prescription drugs and supplies – Certain prescription drugs and supplies require prior approval.** Contact CVS Caremark, our Pharmacy Program administrator, at 1-800-624-5060 (TDD: 1-800-624-5077 for the hearing impaired) to request prior approval, or to obtain a list of drugs and supplies that require prior approval. We will request the information we need to make our coverage determination. You must periodically renew prior approval for certain drugs. See page 100 for more about our prescription drug prior approval program, which is part of our Patient Safety and Quality Monitoring (PSQM) program.

  Please note that updates to the list of drugs and supplies requiring prior approval are made periodically during the year. New drugs and supplies may be added to the list and prior approval criteria may change. Changes to the prior approval list or to prior approval criteria are not considered benefit changes.

  Note: Until we approve them, you must pay for these drugs in full when you purchase them – even if you purchase them at a Preferred retail pharmacy or through our specialty drug pharmacy – and submit the expense(s) to us on a claim form. Preferred pharmacies will not file these claims for you.

  Under **Standard Option**, members may use our Mail Service Prescription Drug Program to fill their prescriptions. However, the Mail Service Prescription Drug Program also will not fill your prescription until you have obtained prior approval. CVS Caremark, the administrator of the Mail Service Prescription Drug Program, will hold your prescription for you up to thirty days. If prior approval is not obtained within 30 days, your prescription will be returned to you along with a letter explaining the prior approval procedures.

  The Mail Service Prescription Drug Program is not available under **Basic Option**.

Surgery by Non-participating providers under Standard Option

You may request prior approval and receive specific benefit information in advance for non-emergency surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. When you contact your local Blue Cross and Blue Shield Plan before your surgery, the Local Plan will review your planned surgery to determine your coverage, the medical necessity of the procedure(s), and the Plan allowance for the services. You can call your Local Plan at the customer service number on the back of your ID card.

Note: Standard Option members are not required to obtain prior approval for surgeries performed by Non-participating providers (unless the surgery is listed on page 23 or is one of the transplant procedures listed on page 23) – even if the charge will be $5,000 or more. If you do not call your Local Plan in advance of the surgery, we will review your claim to provide benefits for the services in accordance with the terms of your coverage.

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

First, you, your representative, your physician, or your hospital must call us at the telephone number listed on the back of your Service Benefit Plan ID card any time prior to admission or before receiving services that require prior approval.

Next, provide the following information:

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

- **Non-urgent care claims**

For non-urgent care claims (including non-urgent concurrent 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 approval. We will notify you of our decision within 15 days after the 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 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 of the claim and notify you of our decision within 72 hours as long as we receive sufficient information to complete the review. (For concurrent care claims that are also urgent care claims, please see *If your treatment needs to be extended* on page 26.) If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) 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 the telephone number listed on the back of your Service Benefit Plan ID card. You may also call OPM's Health Insurance 1 at (202) 606-0727 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 the telephone number listed on the back of your ID card. 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 request.

- **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. If you do not telephone us within two business days, a $500 penalty may apply – see *Warning* under *Inpatient hospital admissions* earlier in this Section and *If your hospital stay needs to be extended* on page 26.

- **Maternity care**

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

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

If your hospital stay – including for maternity care – needs to be extended, you, your representative, your physician, or the hospital must ask us to approve the additional days. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then

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

- **If your treatment needs to be extended**

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.

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 by following the procedures listed below. Note that these procedures apply to requests for reconsideration of concurrent care claims as well (see page 25 for definition). (If you have already received the service, supply, or treatment, then your claim is a **post-service claim** and you 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, approve your request for prior approval for the service, drug, or supply; or
2. Write to you and maintain our denial; or
3. 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.

- **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.

Subject to a request for 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 your covered care:

Cost-sharing

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

Note: You may have to pay the deductible, coinsurance, and/or copayment amount(s) that apply to your care at the time you receive the services.

Copayment

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: If you have Standard Option when you see your Preferred physician, you pay a copayment of $20 for the office visit and we then pay the remainder of the amount we allow for the office visit. (You may have to pay separately for other services you receive while in the physician's office.) When you go into a Preferred hospital, you pay a copayment of $250 per admission. We then pay the remainder of the amount we allow for the covered services you receive.

Copayments do not apply to services and supplies that are subject to a deductible and/or coinsurance amount.

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

Deductible

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

Under Standard Option, the calendar year deductible is $350 per person. Under a family enrollment, the calendar year deductible for each family member is satisfied and benefits are payable for all family members when the combined covered expenses of the family reach $700. For families of two, each family member must fully satisfy his or her individual deductible before this "family deductible" is considered met.

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

Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your Standard Option calendar year deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your Standard Option calendar year deductible ($270) has been satisfied.

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

Under Basic Option, there is **no calendar year deductible**.

Coinsurance

Coinsurance is the percentage of the Plan allowance that you must pay for your care. Your coinsurance is based on the Plan allowance, or billed amount, whichever is less. **Under Standard Option only,** coinsurance does not begin until you have met your calendar year deductible.

Example: You pay 15% of the Plan allowance under Standard Option for durable medical equipment obtained from a Preferred provider, after meeting your $350 calendar year deductible.

If your provider routinely waives your cost

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

Example: If your physician ordinarily charges $100 for a service but routinely waives your 35% Standard Option coinsurance, the actual charge is $65. We will pay $42.25 (65% of the actual charge of $65).

Waivers

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

Differences between our allowance and the bill

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

Often, the provider's bill is more than a fee-for-service plan's allowance. It is possible for a provider's bill to exceed the plan's allowance by a significant amount. Whether or not you have to pay the difference between our allowance and the bill will depend on the type of provider you use. Providers that have agreements with this Plan are Preferred or Participating and will not bill you for any balances that are in excess of our allowance for covered services. See the descriptions appearing below for the types of providers available in this Plan.

- **Preferred providers.** These types of providers have agreements with the Local Plan to limit what they bill our members. Because of that, when you use a Preferred provider, your share of the provider's bill for covered care is limited.

  Under Standard Option, your share consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a Preferred physician who charges $250, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 15% of our $100 allowance ($15). Because of the agreement, your Preferred physician will not bill you for the $150 difference between our allowance and his/her bill.

  Under Basic Option, your share consists only of your copayment or coinsurance amount, since there is no calendar year deductible. Here is an example involving a copayment: You see a Preferred physician who charges $250 for covered services subject to a $25 copayment. Even though our allowance may be $100, you still pay just the $25 copayment. Because of the agreement, your Preferred physician will not bill you for the $225 difference between your copayment and his/her bill.

  Remember, under Basic Option, you must use Preferred providers in order to receive benefits. See page 21 for the exceptions to this requirement.

- **Participating providers.** These types of **Non-preferred providers** have agreements with the Local Plan to limit what they bill our **Standard Option** members.

  Under Standard Option, when you use a Participating provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example: You see a Participating physician who charges $250, but the Plan allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 35% of our $100 allowance ($35). Because of the agreement, your Participating physician will not bill you for the $150 difference between our allowance and his/her bill.

  Under Basic Option, there are no benefits for care performed by Participating providers; you pay all charges. See page 21 for the exceptions to this requirement.

- **Non-participating providers.** These **Non-preferred providers** have no agreement to limit what they will bill you. As a result, your share of the provider's bill could be significantly more than what you would pay for covered care from a Preferred provider. If you plan to use a Non-participating provider for your care, we encourage you to ask the provider about the expected costs and visit our Web site, www.fepblue.org, or call us at the customer service number on the back of your ID card for assistance in estimating your total out-of-pocket expenses.

  Under Standard Option, when you use a Non-participating provider, you will pay your deductible and coinsurance – **plus** any difference between our allowance and the charges on the bill (except in certain circumstances – see pages 145-147). For example, you see a Non-participating physician who charges $250. The Plan allowance is again $100, and you have met your deductible. You are responsible for your coinsurance, so you pay 35% of the $100 Plan allowance or $35. Plus, because there is no agreement between the Non-participating physician and us, the physician can bill you for the $150 difference between our allowance and his/her bill. This means you would pay a total of $185 ($35 + $150) for the Non-participating physician's services, rather than $15 for the same services when performed by a Preferred physician. We encourage you to **always visit Preferred providers for your care**. **Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive.**

  Under Basic Option, there are no benefits for care performed by Non-participating providers; you pay all charges. See page 21 for the exceptions to this requirement.

The tables appearing below illustrate how much **Standard Option** members have to pay out-of-pocket for services performed by Preferred providers, Participating/Member providers, and Non-participating/Non-member providers. The first example shows services provided by a physician and the second example shows facility care billed by an ambulatory surgical facility. In both examples, your calendar year deductible has already been met. **Use this information for illustrative purposes only.**

Basic Option benefit levels for physician care begin on page 37; see page 81 for Basic Option benefit levels that apply to outpatient hospital or ambulatory surgical facility care.

In the following example, we compare how much you have to pay out-of-pocket for services provided by a Preferred physician, a Participating physician, and a Non-participating physician. The table uses our example of a service for which the physician charges $250 and the Plan allowance is $100.

EXAMPLE	Preferred Physician Standard Option		Participating Physician Standard Option		Non-participating Physician Standard Option	
Physician's charge		$250		$250		$250
Our allowance	We set it at:	100	We set it at:	100	We set it at:	100
We pay	85% of our allowance:	85	65% of our allowance:	65	65% of our allowance:	65
You owe: Coinsurance	15% of our allowance:	15	35% of our allowance:	35	35% of our allowance:	35
You owe: Copayment	Not applicable		Not applicable		Not applicable	
+ Difference up to charge?	No:	0	No:	0	Yes:	150
TOTAL YOU PAY		**$15**		**$35**		**$185**

Note: If you had not met any of your **Standard Option** deductible in the above example, only our allowance ($100), which you would pay in full, would count toward your deductible.

In the following example, we compare how much you have to pay out-of-pocket for services billed by a Preferred, Member, and Non-member ambulatory surgical facility for facility care associated with an outpatient surgical procedure. The table uses an example of services for which the ambulatory surgical facility charges $5,000. The Plan allowance is $2,900 when the services are provided at a Preferred or Member facility, and the Plan allowance is $2,500 when the services are provided at a Non-member facility.

EXAMPLE	Preferred Ambulatory Surgical Facility Standard Option		Member Ambulatory Surgical Facility Standard Option		Non-member Ambulatory Surgical Facility* Standard Option	
Facility's charge		$5,000		$5,000		$5,000
Our allowance	We set it at:	2,900	We set it at:	2,900	We set it at:	2,500
We pay	85% of our allowance:	2,465	65% of our allowance:	1,885	65% of our allowance:	1,625
You owe: Coinsurance	15% of our allowance:	435	35% of our allowance:	1,015	35% of our allowance:	875
You owe: Copayment	Not applicable		Not applicable		Not applicable	
+ Difference up to charge?	No:	0	No:	0	Yes:	2,500
TOTAL YOU PAY		**$435**		**$1,015**		**$3,375**

Note: If you had not met any of your **Standard Option** deductible in the above example, $350 of our allowed amount would be applied to your deductible before your coinsurance amount was calculated.

***A Non-member facility may bill you any amount for the services it provides. You are responsible for paying all expenses over our allowance, regardless of the total amount billed, in addition to your calendar year deductible and coinsurance. For example, if you use a Non-member facility that charges $60,000 for facility care related to outpatient bariatric surgery, and we pay the $1,625 amount illustrated above, you would owe $58,375 ($60,000 - $1,625 = $58,375). This example assumes your calendar year deductible has been met.**

Important notice about Non-participating providers!

Preferred hospitals may contract with Non-participating providers to provide certain medical or surgical services at their facilities. Non-participating providers have no agreements with your Local Plan to limit what they can bill you. Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive.

Here is an example: You have coverage under Standard Option and go into a Preferred hospital for surgery. During surgery, you receive the services of a Non-participating anesthesiologist. Under Standard Option, members pay 15% of the Non-participating Provider Allowance plus any difference between that allowance and the amount billed (after the member's $350 calendar year deductible has been satisfied), for services provided in Preferred facilities by Non-participating anesthesiologists (see page 62). For Preferred provider services, members pay only a coinsurance amount of 15% of the Preferred Provider Allowance after meeting the $350 calendar year deductible.

In this example, the Non-participating anesthesiologist charges $1,200 for his/her services. Our Non-participating Provider Allowance for those services is $400. For the Non-preferred anesthesiologist's services, you would be responsible for paying 15% of the allowance ($60), plus the $800 difference between the allowance and the amount billed, for a total of $860. If you instead received services from a Preferred anesthesiologist, you would pay only 15% of the $400 allowance (after meeting your deductible), or $60, resulting in a savings to you of $800 ($860 - $60 = $800).

Always request Preferred providers for your care. Call your Local Plan at the number listed on the back of your ID card or go to our Web site, www.fepblue.org, to check the contracting status of your provider or to locate a Preferred provider near you.

Under Basic Option, there are no benefits for care performed by Participating/Member or Non-participating/Non-member providers. You must use Preferred providers in order to receive benefits. See page 21 for the exceptions to this requirement.

Your costs for other care

- **Overseas care. Under Standard and Basic Options,** we pay overseas claims at Preferred benefit levels. In most cases, our Plan allowance for professional provider services is based on our Overseas Fee Schedule. Most overseas professional providers are under no obligation to accept our allowance, and you must pay any difference between our payment and the provider's bill. For facility care you receive overseas, we provide benefits in full after you pay the applicable copayment or coinsurance (and, under Standard Option, any deductible amount that may apply). See Section 5(i) for more information about our overseas benefits.
- **Dental care. Under Standard Option,** we pay scheduled amounts for covered dental services and you pay balances as described in Section 5(g). **Under Basic Option,** you pay $25 for any covered evaluation and we pay the balance for covered services. **Basic Option members** must use **Preferred** dentists in order to receive benefits. See Section 5(g) for a listing of covered dental services and additional payment information.
- **Hospital care. Under Standard and Basic Options,** you pay the coinsurance or copayment amounts listed in Section 5(c). **Under Standard Option,** you must meet your deductible before we begin providing benefits for certain hospital-billed services. **Under Basic Option,** you must use **Preferred** facilities in order to receive benefits. See page 21 for the exceptions to this requirement.

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

Under Standard and Basic Options, we limit your annual out-of-pocket expenses for the covered services you receive to protect you from unexpected health care costs. When your eligible out-of-pocket expenses reach this catastrophic protection maximum, you no longer have to pay the associated cost-sharing amounts for the rest of the calendar year.

Note: Certain types of expenses do not accumulate to the maximum.

Standard Option maximums:

- **Preferred Provider maximum -** For a Self Only enrollment, your out-of-pocket maximum for your deductible, and for eligible coinsurance and copayment amounts, is $5,000 when you use Preferred providers. For a Self and Family enrollment, your out-of-pocket maximum for these types of expenses is $6,000 for Preferred provider services. Only eligible expenses for Preferred provider services count toward these limits.
- **Non-preferred Provider maximum -** For a Self Only enrollment, your out-of-pocket maximum for your deductible, and for eligible coinsurance and copayment amounts, is $7,000 when you use Non-preferred providers. For a Self and Family enrollment, your out-of-pocket maximum for these types of expenses is $8,000 for Non-preferred provider services. For either enrollment type, eligible expenses for the services of Preferred providers also count toward these limits.

Basic Option maximum:

- **Preferred Provider maximum -** For a Self Only enrollment, your out-of-pocket maximum for eligible coinsurance and copayment amounts, is $5,500 when you use Preferred providers. For a Self and Family enrollment, your out-of-pocket maximum for these types of expenses is $7,000 when you use Preferred providers. Only eligible expenses for Preferred provider services count toward these limits.

The following expenses are not included under this feature. These expenses do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay them even after your expenses exceed the limits described above.

- The difference between the Plan allowance and the billed amount. See pages 29-30;
- Expenses for services, drugs, and supplies in excess of our maximum benefit limitations;

- Under Standard Option, your 35% coinsurance for inpatient care in a Non-member hospital;
- Under Standard Option, your 35% coinsurance for outpatient care by a Non-member facility;
- Your expenses for dental services in excess of our fee schedule payments under Standard Option. See Section 5(g);
- The $500 penalty for failing to obtain precertification, and any other amounts you pay because we reduce benefits for not complying with our cost containment requirements; and
- Under Basic Option, your expenses for care received from Participating/Non-participating professional providers or Member/Non-member facilities, except for coinsurance and copayments you pay in those special situations where we do pay for care provided by Non-preferred providers. Please see page 21 for the exceptions to the requirement to use Preferred providers.

Carryover

Note: If you change to another plan during Open Season, we will continue to provide benefits between January 1 and the effective date of your new plan.

- If you had already paid the out-of-pocket maximum, we will continue to provide benefits as described on page 31 and on this page until the effective date of your new plan.
- If you had not yet paid the out-of-pocket maximum, we will apply any expenses you incur in January (before the effective date of your new plan) to our prior year's out-of-pocket maximum. Once you reach the maximum, you do not need to pay our deductibles, copayments, or coinsurance amounts (except as shown on page 31 and on this page) from that point until the effective date of your new plan.

Note: Because benefit changes are effective January 1, we will apply our next year's benefits to any expenses you incur in January.

Note: If you change options in this Plan during the year, we will credit the amounts already accumulated toward the catastrophic protection out-of-pocket limit of your old option to the catastrophic protection out-of-pocket limit of your new option. If you change from Self Only to Self and Family, or vice versa, during the calendar year, please call us about your out-of-pocket accumulations and how they carry over.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

Note: We will generally first seek recovery from the provider if we paid the provider directly, or from the person (covered family member, guardian, custodial parent, etc.) to whom we sent our payment.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Standard and Basic Option Benefits

See pages 15-17 for how our benefits changed this year. Pages 153-154 and page 155 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Standard and Basic Option Overview 35

Section 5(a) Medical services and supplies provided by physicians and other health care professionals 36
- Diagnostic and treatment services 37
- Lab, X-ray, and other diagnostic tests 39
- Preventive care, adult 41
- Preventive care, children 45
- Maternity care 46
- Family planning 48
- Infertility services 49
- Allergy care 50
- Treatment therapies 51
- Physical therapy, occupational therapy, speech therapy, and cognitive therapy 52
- Hearing services (testing, treatment, and supplies) 53
- Vision services (testing, treatment, and supplies) 53
- Foot care 55
- Orthopedic and prosthetic devices 55
- Durable medical equipment (DME) 57
- Medical supplies 58
- Home health services 59
- Manipulative treatment 60
- Alternative treatments 60
- Educational classes and programs 61

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals 62
- Surgical procedures 63
- Reconstructive surgery 66
- Oral and maxillofacial surgery 67
- Organ/tissue transplants 68
- Anesthesia 76

Section 5(c) Services provided by a hospital or other facility, and ambulance services 77
- Inpatient hospital 78
- Outpatient hospital or ambulatory surgical center 81
- Extended care benefits/Skilled nursing care facility benefits 85
- Hospice care 86
- Ambulance 89

Section 5(d) Emergency services/accidents 90
- Accidental injury 91
- Medical emergency 92
- Ambulance 93

Section 5(e) Mental health and substance abuse benefits 94
- Professional services 94
- Inpatient hospital or other covered facility 96
- Outpatient hospital or other covered facility 96
- Not covered (Inpatient or Outpatient) 97

Section 5(f) Prescription drug benefits 98
- Covered medications and supplies 101
- Preferred Retail Pharmacy Program 105
- Mail Service Prescription Drug Program 107
- Specialty Drug Pharmacy Program 108

Section 5(g) Dental benefits 112
- Accidental injury benefit 112
- Dental benefits 113

Section 5(h) Special features 118
Health Tools 118
Services for the deaf and hearing impaired 118
Web accessibility for the visually impaired 118
Travel benefit/services overseas 118
Healthy Families 118
WalkingWorks® Wellness Program 118
Blue Health Assessment 119
Diabetes Management Incentive Program 119
MyBlue® Customer eService 120
National Doctor & Hospital Finder℠ 120
Care Management Programs 120
Flexible benefits option 120

Section 5(i) Services, drugs, and supplies provided overseas 121

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2014 153

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2014 155

Standard and Basic Option Overview

This Plan offers both a Standard and Basic Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Standard and Basic Option 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 Standard and Basic Option benefits, contact us at the customer service telephone number on the back of your Service Benefit Plan ID card or on our Web site at www.fepblue.org.

Each option offers unique features.

Standard Option

When you have Standard Option, you can use both Preferred and Non-preferred providers. However, your out-of-pocket expenses are lower when you use Preferred providers and Preferred providers will submit claims to us on your behalf. Standard Option has a calendar year deductible for some services and a $20 copayment for office visits to primary care providers ($30 for specialists). Standard Option also features a Preferred Retail Pharmacy Program, a Preferred Mail Service Drug Program, and a Preferred Specialty Drug Pharmacy Program.

Basic Option

Basic Option does not have a calendar year deductible. Most services are subject to copayments ($25 for primary care providers and $35 for specialists). Members do not need to have referrals to see specialists. You must use Preferred providers for your care to be eligible for benefits, except in certain circumstances, such as emergency care. Preferred providers will submit claims to us on your behalf. Basic Option also offers a Preferred Retail Pharmacy Program and a Preferred Specialty Drug Pharmacy Program.

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.
- Please refer to Section 3, *How you receive benefits*, for a list of providers we consider to be primary care providers and other health care professionals.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a physician, a physical therapist, or an outpatient facility.
- The amounts listed in this Section are for the charges billed by a physician or other health care professional for your medical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital or other outpatient facility, etc.).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
  - The calendar year deductible is $350 per person ($700 per family).
  - We provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our payment and the billed amount.
- **Under Basic Option,**
  - There is **no calendar year deductible**.
  - **You must use Preferred providers in order to receive benefits. See below and page 21 for the exceptions to this requirement.**
  - We provide benefits at Preferred benefit levels for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our payment and the billed amount.

Benefit Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Diagnostic and treatment services	**Standard Option**	**Basic Option**
Outpatient professional services of physicians and other health care professionals: • Consultations • Second surgical opinions • Clinic visits • Office visits • Home visits • Initial examination of a newborn needing definitive treatment when covered under a family enrollment • Pharmacotherapy (medication management) [see Section 5(f) for prescription drug coverage] ***Note:*** Please refer to pages 39-40 for our coverage of laboratory, X-ray, and other diagnostic tests billed for by a health care professional, and to pages 81-83 for our coverage of these services when billed for by a facility, such as the outpatient department of a hospital.	Preferred primary care provider or other health care professional: $20 copayment for the visit charge (no deductible) Preferred specialist: $30 copayment for the visit charge (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $35 copayment per visit ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about "agents.") Participating/Non-participating: You pay all charges
Inpatient professional services: • During a hospital stay • Services for nonsurgical procedures when ordered, provided, and billed by a physician during a covered inpatient hospital admission • Medical care by the attending physician (the physician who is primarily responsible for your care when you are hospitalized) on days we pay inpatient hospital benefits ***Note:*** A consulting physician employed by the hospital is not the attending physician. • Consultations when requested by the attending physician • Concurrent care – hospital inpatient care by a physician other than the attending physician for a condition not related to your primary diagnosis, or because the medical complexity of your condition requires this additional medical care • Physical therapy by a physician other than the attending physician • Initial examination of a newborn needing definitive treatment when covered under a family enrollment • Pharmacotherapy (medication management) [see Section 5(c) for our coverage of drugs you receive while in the hospital] • Second surgical opinion • Nutritional counseling when billed by a covered provider	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

Diagnostic and treatment services – continued on next page

Diagnostic and treatment services *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Not covered: • *Routine services except for those Preventive care services described on pages 41-45* • *Telephone consultations and online medical evaluation and management services* • *Private duty nursing* • *Standby physicians* • *Routine radiological and staff consultations required by hospital rules and regulations* • *Inpatient physician care when your hospital admission or portion of an admission is not covered [see Section 5(c)]* ***Note:*** *If we determine that a hospital admission is not covered, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.*	*All charges*	*All charges*

Lab, X-ray, and other diagnostic tests	You Pay	
	Standard Option	Basic Option
Diagnostic tests limited to: • Laboratory tests (such as blood tests and urinalysis) • Pathology services • EKGs ***Note:*** See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Preferred: Nothing ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about "agents.") Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
Diagnostic tests including but not limited to: • EEGs • Neurological testing • Ultrasounds • X-rays (including set-up of portable X-ray equipment) ***Note:*** See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Preferred: $40 copayment ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about "agents.") Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount in addition to the Preferred copayment listed above.

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

Lab, X-ray, and other diagnostic tests *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Diagnostic tests limited to: • Bone density tests • CT scans/MRIs/PET scans • Angiographies • Genetic testing ***Note:*** Benefits are available for specialized diagnostic genetic testing when it is medically necessary to diagnose and/or manage a patient's existing medical condition. Diagnostic BRCA testing is covered only for members with a cancer diagnosis. BRCA testing is limited to one test per lifetime whether covered as a diagnostic test or paid under Preventive Care benefits (see page 43). ***Note:*** See pages 41, 43, and 44 in this Section for coverage of preventive genetic testing/screening services related to family history of cancer or other disease. • Nuclear medicine • Sleep studies ***Note:*** See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Preferred: $100 copayment ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about "agents.") Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount in addition to the Preferred copayment listed above.

Preventive care, adult	You Pay	
	Standard Option	Basic Option
Benefits are provided for preventive care services for adults age 22 and over, including services recommended under the Affordable Care Act (ACA). For a complete list of preventive care services recommended under the ACA, visit: www.healthcare.gov/what-are-my-preventive-care-benefits. Preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) are listed at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. Covered services include: • Visits/exams for preventive care ***Note:*** See the definition of *Preventive Care, Adult* on page 147 for included health screening services. • Individual counseling on prevention and reducing health risks ***Note:*** Preventive care benefits are not available for group counseling. ***Note:*** Preventive care benefits for each of the services listed below are limited to one per calendar year. • Chest X-ray • EKG • Urinalysis • General health panel • Basic or comprehensive metabolic panel test • CBC • Fasting lipoprotein profile (total cholesterol, LDL, HDL, and/or triglycerides) • Screening for alcohol/substance abuse ***Note:*** See pages 61 and 109 for our coverage of smoking and tobacco cessation treatment. • Genetic counseling and evaluation for women whose family history is associated with an increased risk for harmful mutations in BRCA1 or BRCA2 genes ***Note:*** Preventive care benefits are available for BRCA testing only as described on page 43. • Screening for chlamydial infection • Screening for gonorrhea infection • Screening for Human Papillomavirus (HPV) for females • Screening for Human Immunodeficiency virus (HIV) infection • Screening for syphilis infection • Administration and interpretation of a Health Risk Assessment (HRA) questionnaire (see *Definitions*) ***Note:*** As a member of the Service Benefit Plan, you have access to the Blue Cross and Blue Shield HRA, called the "Blue Health Assessment" questionnaire. Completing the questionnaire entitles you to receive special benefit incentives. See Section 5(h) for complete information.	Preferred: Nothing (no deductible) ***Note:*** If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services. Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred: Nothing ***Note:*** If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. ***Note:*** When billed by a Preferred facility, such as the outpatient department of a hospital, we provide benefits as shown here for Preferred providers. ***Note:*** Benefits are not available for visits/exams for preventive care, associated laboratory tests, screening colonoscopies, or routine immunizations performed at Member or Non-member facilities. ***Note:*** See Section 5(c) for our payment levels for covered cancer screenings and ultrasound screening for aortic abdominal aneurysm billed for by Member or Non-member facilities and performed on an outpatient basis.

Preventive care, adult – continued on next page

Preventive care, adult *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
• Colorectal cancer tests, including: – Fecal occult blood test – Screening colonoscopy (see page 63 for our payment levels for diagnostic colonoscopies) – Sigmoidoscopy – Double contrast barium enema • Prostate cancer tests – Prostate Specific Antigen (PSA) test • Cervical cancer tests (including Pap tests) • Screening mammograms • Ultrasound for aortic abdominal aneurysm • Osteoporosis screening – annual screening for women age 60 and over ***Note:*** Preventive care benefits for each of the services listed above are limited to one per calendar year. • Nutritional counseling when billed by a covered provider ***Note:*** Benefits are limited to individual nutritional counseling services. We do not provide benefits for group counseling services. ***Note:*** If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services.	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred: Nothing Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. ***Note:*** When billed by a Preferred facility, such as the outpatient department of a hospital, we provide benefits as shown here for Preferred providers. ***Note:*** Benefits are not available for visits/exams for preventive care, associated laboratory tests, screening colonoscopies, or routine immunizations performed at Member or Non-member facilities. ***Note:*** See Section 5(c) for our payment levels for covered cancer screenings and ultrasound screening for aortic abdominal aneurysm billed for by Member or Non-member facilities and performed on an outpatient basis.

Preventive care, adult – continued on next page

Preventive care, adult *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
BRCA testing for females, age 18 and over, who have not been diagnosed with breast or ovarian cancer, and whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes. BRCA testing is limited to one BRCA test per lifetime. Eligible females must meet at least one of the following family history criteria (see note below for females of Ashkenazi Jewish heritage): • Two first-degree relatives with breast cancer, one of whom was diagnosed at age 50 or younger; or • A combination of three or more first- or second-degree relatives with breast cancer regardless of age at diagnosis; or • A combination of both breast and ovarian cancer among first- and second-degree relatives; or • A first-degree relative with bilateral breast cancer; or • A combination of two or more first- or second-degree relatives with ovarian cancer regardless of age at diagnosis; or • A first- or second-degree relative with both breast and ovarian cancer at any age; or • A history of breast cancer in a male relative ***Note:*** The family history criteria listed above do not apply to females of Ashkenazi Jewish heritage. Females of Ashkenazi Jewish heritage must meet one of the following family history criteria: • Any first-degree relative with breast or ovarian cancer; or • Two second-degree relatives on the same side of the family with breast or ovarian cancer First-degree relatives are defined as: parents, siblings, and children of the woman being tested. Second-degree relatives are defined as: grandparents, aunts, uncles, nieces, nephews, grandchildren, and half-siblings (siblings with one shared biological parent) of the woman being tested. Relatives may be living or deceased. ***Note:*** BRCA testing is limited to one test per lifetime whether paid under Preventive Care benefits or covered as a diagnostic test (see page 40 for our coverage of diagnostic BRCA testing). ***Note:*** Preventive care benefits are not available for surgical removal of breasts or ovaries.	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories, you pay any difference between our allowance and the billed amount. ***Note:*** When billed by a Preferred facility, such as the outpatient department of a hospital, we provide benefits as shown here for Preferred providers. Benefits are not available for BRCA testing performed at Member or Non-member facilities.

Preventive care, adult – continued on next page

Preventive care, adult *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Routine immunizations [as licensed by the U.S. Food and Drug Administration (FDA)], limited to: • Hepatitis (Types A and B) for patients with increased risk or family history • Herpes Zoster (shingles)* • Human Papillomavirus (HPV)* • Influenza (flu)* • Measles, Mumps, Rubella • Meningococcal* • Pneumococcal* • Tetanus, Diphtheria, Pertussis booster (one every 10 yrs) • Varicella *Many Preferred retail pharmacies participate in our vaccine network. See page 103 for our coverage of these vaccines when provided by pharmacies in the vaccine network.	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** We waive your deductible and coinsurance amount for services billed by Participating/ Non-participating providers related to Influenza (flu) vaccines. If you use a Non-participating provider, you pay any difference between our allowance and the billed amount. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred: Nothing Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** We provide benefits for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. If you use a Non-participating provider, you pay any difference between our allowance and the billed amount. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.
Note: U.S. FDA licensure may restrict the use of the immunizations and vaccines listed above to certain age ranges, frequencies, and/or other patient-specific indications, including gender. ***Note:*** If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services. ***Note:*** See page 104 for our payment levels for medicines to promote better health as recommended under the Affordable Care Act. ***Note:*** The benefits listed above and on pages 41-43 do not apply to children up to age 22. (See benefits under *Preventive care, children*, this Section.)	See above and pages 41-43	See above and pages 41-43
Not covered: • *Genetic testing/screening related to family history of cancer or other disease, except for BRCA testing/screening as described on page 43* ***Note:*** *See page 40 for our coverage of medically necessary diagnostic genetic testing.* • *Group counseling on prevention and reducing health risks* • *Self-administered health risk assessments (other than the Blue Health Assessment)* • *Screening services requested solely by the member, such as commercially advertised heart scans, body scans, and tests performed in mobile traveling vans*	*All charges*	*All charges*

Preventive care, children	You Pay	
	Standard Option	Basic Option
Benefits are provided for preventive care services for children up to age 22, including services recommended under the Affordable Care Act (ACA), and by the American Academy of Pediatrics (AAP). For a complete list of preventive care services recommended under the ACA, visit: www.healthcare.gov/what-are-my-preventive-care-benefits. Preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) are listed at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. Covered services include: • Healthy newborn visits and screenings (inpatient or outpatient) • Visits/exams for preventive care • Laboratory tests • Hearing and vision screenings • Routine immunizations as licensed by the U.S. Food and Drug Administration (FDA) limited to: Diphtheria, Tetanus, Pertussis Hemophilus Influenza type b (Hib) Hepatitis (Types A and B) Human Papillomavirus (HPV) Inactivated Poliovirus Measles, Mumps, Rubella Meningococcal Pneumococcal Rotavirus Influenza (flu) Varicella ***Note:*** U.S. FDA licensure may restrict the use of certain immunizations and vaccines to specific age ranges, frequencies, and/or other patient-specific indications, including gender. • Screening for chlamydial infection • Screening for gonorrhea infection • Screening for Human Papillomavirus (HPV) for females • Screening for Human Immunodeficiency virus (HIV) infection • Screening for syphilis infection ***Note:*** Benefits for sexually transmitted infection (STI) screening tests are limited to one test per STI per year. • Nutritional counseling services (see page 42) ***Note:*** See page 104 for our payment levels for medicines to promote better health as recommended under the Affordable Care Act. ***Note:*** If your child receives both preventive and diagnostic services from a Preferred provider on the same day, you are responsible for paying the cost-share for the diagnostic services.	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** We waive the deductible and coinsurance amount for services billed by Participating/ Non-participating providers related to Influenza (flu) vaccines. If you use a Non-participating provider, you pay any difference between our allowance and the billed amount. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred: Nothing Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. ***Note:*** We provide benefits for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. If you use a Non-participating provider, you pay any difference between our allowance and the billed amount. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.

Maternity care	You Pay	
	Standard Option	Basic Option
Maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage, such as: • Prenatal care (including ultrasound, laboratory, and diagnostic tests) • Tocolytic therapy and related services (when provided and billed by a home infusion therapy company or a home health care agency) ***Note:*** Maternity care benefits are not provided for oral tocolytic agents. See Section 5(f) for prescription drug coverage (including oral tocolytic agents). ***Note:*** Benefits for home nursing visits related to covered tocolytic therapy are subject to the visit limitations described on page 59. • Delivery • Postpartum care • Assistant surgeons/surgical assistance if required because of the complexity of the delivery • Anesthesia (including acupuncture) when requested by the attending physician and performed by a certified registered nurse anesthetist (CRNA) or a physician other than the operating physician (surgeon) or the assistant • Breastfeeding education and individual coaching on breastfeeding by medical practitioners such as physicians, physician assistants, midwives, nurse practitioners/clinical specialists, and registered nurse certified lactation consultants ***Note:*** See page 47 for our coverage of breast pump kits. • Mental health treatment for postpartum depression and depression during pregnancy ***Note:*** We provide benefits to cover up to 4 visits per year in full to treat depression associated with pregnancy (i.e., depression during pregnancy, postpartum depression, or both) when you use a Preferred provider. See Section 5(e) for our coverage of mental health visits to Non-preferred providers and benefits for additional mental health services. ***Note:*** See page 42 for our coverage of nutritional counseling.	Preferred: Nothing (no deductible) ***Note:*** For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use Preferred providers. Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** You may request prior approval and receive specific benefit information in advance for the delivery itself and any other maternity-related surgical procedures to be provided by a Non-participating physician when the charge for that care will be **$5,000 or more**. Call your Local Plan at the customer service number on the back of your ID card to obtain information about your coverage and the Plan allowance for the services.	Preferred: Nothing ***Note:*** For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered inpatient services is limited to $175 per admission. For outpatient facility services related to maternity, see page 82. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you are responsible only for any difference between our allowance and the billed amount.

Maternity care – continued on next page

Maternity care *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 26 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary. • We cover routine nursery care of the newborn child when performed during the covered portion of the mother's maternity stay and billed by the facility. We cover other care of an infant who requires professional services or non-routine treatment, only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. ***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. Regular medical or surgical benefits apply rather than maternity benefits. ***Note:*** See page 63 for our payment levels for circumcision.		
• Breast pump kit, limited to one of the two kits listed below, per calendar year for women who are pregnant and/or nursing – Ameda Manual pump kit – or – Ameda Double Electric pump kit ***Note:*** The breast pump kit will include a supply of 150 Ameda milk storage bags. You may order Ameda milk storage bags, limited to 150 bags every 90 days, even if you own your own breast pump. ***Note:*** Benefits for the breast pump kit and milk storage bags are only available when you order them through CVS Caremark by calling 1-800-262-7890.	Nothing (no deductible)	Nothing

Maternity care – continued on next page

Maternity care *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Not covered: • *Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest* • *Genetic testing/screening of the baby's father (see page 40 for our coverage of medically necessary diagnostic genetic testing)* • *Childbirth preparation, Lamaze, and other birthing/parenting classes* • *Breast pumps and milk storage bags except as stated on page 47* • *Breastfeeding supplies other than those contained in the breast pump kit described on page 47 including clothing (e.g., nursing bras), baby bottles, or items for personal comfort or convenience (e.g., nursing pads)* • *Maternity care for women not enrolled in this Plan*	*All charges*	*All charges*
Family planning		
A range of voluntary family planning services for women, limited to: • Contraceptive counseling • Diaphragms and contraceptive rings • Injectable contraceptives • Intrauterine devices (IUDs) • Implantable contraceptives • Voluntary sterilization (tubal ligation or tubal occlusion/tubal blocking procedures only) ***Note:*** See page 63 for our coverage of voluntary sterilization for men. ***Note:*** We also provide benefits for professional services associated with voluntary sterilizations and with the fitting, insertion, implantation, or removal of the contraceptives listed above at the payment levels shown here. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

Family planning – continued on next page

Family planning *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
• Oral and transdermal contraceptives ***Note:*** We waive your cost-share for generic oral and transdermal contraceptives when you purchase them at a Preferred retail pharmacy or, for Standard Option only, through the Mail Service Prescription Drug Program. See page 102 for more information. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
Not covered: • *Reversal of voluntary surgical sterilization* • *Contraceptive devices not described above* • *Over-the-counter (OTC) contraceptives, except as described in Section 5(f)*	*All charges*	*All charges*
Infertility services		
Diagnosis and treatment of infertility, except as shown in *Not covered* ***Note:*** See Section 5(f) for prescription drug coverage.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $35 copayment per visit ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about "agents.") Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.

Infertility services – continued on next page

Infertility services *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Not covered: • *Assisted reproductive technology (ART) and assisted insemination procedures, including but not limited to:* – *Artificial insemination (AI)* – *In vitro fertilization (IVF)* – *Embryo transfer and Gamete Intrafallopian Transfer (GIFT)* – *Zygote Intrafallopian Transfer (ZIFT)* – *Intravaginal insemination (IVI)* – *Intracervical insemination (ICI)* – *Intracytoplasmic sperm injection (ICSI)* – *Intrauterine insemination (IUI)* • *Services and supplies related to ART and assisted insemination procedures* • *Cryopreservation or storage of sperm (sperm banking), eggs, or embryos* • *Infertility drugs used in conjunction with ART and assisted insemination procedures* • *Services, supplies, or drugs provided to individuals not enrolled in this Plan*	*All charges*	*All charges*
Allergy care		
• Testing and treatment, including materials (such as allergy serum) • Allergy injections	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit; nothing for injections Preferred specialist: $35 copayment per visit; nothing for injections Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*	*All charges*

Treatment therapies	You Pay	
	Standard Option	Basic Option
Outpatient treatment therapies: • Chemotherapy and radiation therapy ***Note:*** We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under *Organ/tissue transplants* in Section 5(b). See also, *Other services* under *You need prior Plan approval for certain services* in Section 3 (pages 23-24). • Intensity-modulated radiation therapy (IMRT) ***Note:*** **You must get prior approval for outpatient IMRT related to cancers other than head, neck, breast, or prostate cancer.** Please refer to page 23 for more information. • Renal dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy – Home IV or infusion therapy ***Note:*** Home nursing visits associated with Home IV/infusion therapy are covered as shown under *Home health services* on page 59. • Outpatient cardiac rehabilitation ***Note:*** See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital. ***Note:*** See page 60 for our coverage of osteopathic and chiropractic manipulative treatment.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $35 copayment per visit ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about "agents.") Participating/Non-participating: You pay all charges
Inpatient treatment therapies: • Chemotherapy and radiation therapy ***Note:*** We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under *Organ/tissue transplants* in Section 5(b). See also, *Other services* under *You need prior Plan approval for certain services* in Section 3 (pages 23-24). • Renal dialysis – Hemodialysis and peritoneal dialysis • Pharmacotherapy (medication management) [see Section 5(c) for our coverage of drugs administered in connection with these treatment therapies]	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

Physical therapy, occupational therapy, speech therapy, and cognitive therapy	You Pay	
	Standard Option	Basic Option
• Physical therapy, occupational therapy, and speech therapy • Cognitive rehabilitation therapy ***Note:*** When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for professional care, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $20 copayment per visit (no deductible) Preferred specialist: $30 copayment per visit (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three. ***Note:*** Visits that you pay for while meeting your calendar year deductible count toward the limit cited above. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $35 copayment per visit ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about "agents.") ***Note:*** Benefits are limited to 50 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three. Participating/Non-participating: You pay all charges ***Note:*** See Section 5(c) for our payment levels for rehabilitative therapies billed for by the outpatient department of a hospital.
Not covered: • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Maintenance or palliative rehabilitative therapy* • *Exercise programs* • *Hippotherapy (exercise on horseback)* • *Massage therapy*	*All charges*	*All charges*

Hearing services (testing, treatment, and supplies)	You Pay	
	Standard Option	**Basic Option**
• Hearing tests related to illness or injury • Testing and examinations for prescribing hearing aids ***Note:*** For our coverage of hearing aids and related services, see page 56.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $35 copayment per visit ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about "agents.") Participating/Non-participating: You pay all charges
Not covered: • *Routine hearing tests (except as indicated on page 45)* • *Hearing aids (except as described on page 56)*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)		
Benefits are limited to one pair of eyeglasses, replacement lenses, or contact lenses per incident prescribed: • To correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery; • If the condition can be corrected by surgery, but surgery is not an appropriate option due to age or medical condition; • For the nonsurgical treatment for amblyopia and strabismus, for children from birth through age 18 ***Note:*** Benefits are provided for refractions only when the refraction is performed to determine the prescription for the one pair of eyeglasses, replacement lenses, or contact lenses provided per incident as described above.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

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

Vision services (testing, treatment, and supplies) *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
• Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 18 ***Note:*** See page 53 for our coverage of eyeglasses, replacement lenses, or contact lenses when prescribed as nonsurgical treatment for amblyopia and strabismus. ***Note:*** See Section 5(b), *Surgical procedures*, for coverage for surgical treatment of amblyopia and strabismus. ***Note:*** See pages 39-40 in this Section for our payment levels for Lab, X-ray, and other diagnostic tests performed or ordered by your provider. Benefits are not available for refractions except as described on page 53.	Preferred primary care provider or other health care professional: $20 copayment (no deductible) Preferred specialist: $30 copayment (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $35 copayment per visit ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about "agents.") Participating/Non-participating: You pay all charges
Not covered: • *Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as described on page 53* • *Deluxe lens features for eyeglasses or contact lenses such as special coating, polarization, UV treatment, etc.* • *Multifocal, accommodating, toric, or other premium intraocular lenses (IOLs) including Crystalens, ReStor, and ReZoom* • *Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described above* • *LASIK, INTACS, radial keratotomy, and other refractive surgical services* • *Refractions, including those performed during an eye examination related to a specific medical condition, except as described on page 53*	*All charges*	*All charges*

Foot care	You Pay	
	Standard Option	Basic 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. ***Note:*** See Section 5(b) for our coverage for surgical procedures.	Preferred primary care provider or other health care professional: $20 copayment for the office visit (no deductible); 15% of the Plan allowance for all other services (deductible applies) Preferred specialist: $30 copayment for the office visit (no deductible); 15% of the Plan allowance for all other services (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $35 copayment per visit ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about "agents.") Participating/Non-participating: You pay all charges
Not covered: Routine foot care, such as cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above	*All charges*	*All charges*
Orthopedic and prosthetic devices		
Orthopedic braces and prosthetic appliances such as: • Artificial limbs and eyes • Functional foot orthotics when prescribed by a physician • Rigid devices attached to the foot or a brace, or placed in a shoe • Replacement, repair, and adjustment of covered devices • Following a mastectomy, breast prostheses and surgical bras, including necessary replacements • Surgically implanted penile prostheses to treat erectile dysfunction ***Note:*** A **prosthetic appliance** is a device that is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body. We provide hospital benefits for internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b).	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Orthopedic and prosthetic devices – continued on next page

Orthopedic and prosthetic devices *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
• Hearing aids for children up to age 22, limited to $2,500 per calendar year • Hearing aids for adults age 22 and over, limited to $2,500 every 3 calendar years ***Note:*** Benefits for hearing aid dispensing fees, fittings, batteries, and repair services are included in the benefit limits described above.	Any amount over $2,500 (no deductible)	Any amount over $2,500
• Bone anchored hearing aids when medically necessary for members with traumatic injury or malformation of the external ear or middle ear (such as a surgically induced malformation or congenital malformation), limited to $5,000 per calendar year	Any amount over $5,000 (no deductible)	Any amount over $5,000
• Wigs for hair loss due to the treatment of cancer ***Note:*** Benefits for wigs are paid at 100% of the billed amount, limited to $350 for one wig per lifetime.	Any amount over $350 for one wig per lifetime (no deductible)	Any amount over $350 for one wig per lifetime
Not covered: • *Shoes (including diabetic shoes)* • *Over-the-counter orthotics* • *Arch supports* • *Heel pads and heel cups* • *Wigs (including cranial prostheses), except for scalp hair prosthesis for hair loss due to the treatment of cancer, as stated above* • *Hearing aid accessories or supplies (including remote controls and warranty packages)*	*All charges*	*All charges*

Durable medical equipment (DME)	You Pay	
	Standard Option	Basic Option
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Home dialysis equipment • Oxygen equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Continuous passive motion (CPM) devices • Dynamic orthotic cranioplasty (DOC) devices • Insulin pumps • Other items that we determine to be DME, such as compression stockings ***Note:*** We cover DME at Preferred benefit levels only when you use a Preferred DME provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred DME providers.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** See Section 5(c) for our coverage of DME provided and billed by a facility.	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges ***Note:*** See Section 5(c) for our coverage of DME provided and billed by a facility.
• Speech-generating devices, limited to $1,250 per calendar year	Any amount over $1,250 per year (no deductible)	Any amount over $1,250 per year

Durable medical equipment (DME) – continued on next page

Durable medical equipment (DME) *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Not covered: *Exercise and bathroom equipment* *Lifts, such as seat, chair, or van lifts* *Car seats* *Diabetic supplies, except as described in Section 5(f) or when Medicare Part B is primary* *Air conditioners, humidifiers, dehumidifiers, and purifiers* *Breast pumps, except as described on page 47* *Communications equipment, devices, and aids (including computer equipment) such as "story boards" or other communication aids to assist communication-impaired individuals (except for speech-generating devices as listed on page 57)* *Equipment for cosmetic purposes* *Topical Hyperbaric Oxygen Therapy (THBO)*	*All charges*	*All charges*
Medical supplies		
• Medical foods for children with inborn errors of amino acid metabolism • Medical foods and nutritional supplements when administered by catheter or nasogastric tubes • Medical foods, as defined by the U.S. Food and Drug Administration, that are administered orally and that provide the sole source (100%) of nutrition, for children up to age 22, for up to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate) ***Note:*** See Section 10, *Definitions*, for more information about medical foods. • Ostomy and catheter supplies • Oxygen ***Note:*** When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for oxygen, according to the contracting status of the facility. • Blood and blood plasma, except when donated or replaced, and blood plasma expanders ***Note:*** We cover medical supplies at Preferred benefit levels only when you use a Preferred medical supply provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred medical supply providers.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
Not covered: • *Infant formulas used as a substitute for breastfeeding* *Diabetic supplies, except as described in Section 5(f) or when Medicare Part B is primary*	*All charges*	*All charges*

Home health services	You Pay	
	Standard Option	Basic Option
Home nursing care for two (2) hours per day when: • A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and • A physician orders the care	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** Benefits for home nursing care are limited to 50 visits per person, per calendar year. ***Note:*** Visits that you pay for while meeting your calendar year deductible count toward the annual visit limit.	Preferred: $25 copayment per visit ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about "agents.") ***Note:*** Benefits for home nursing care are limited to 25 visits per person, per calendar year. Participating/Non-participating: You pay all charges
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for bathing, feeding, exercising, moving the patient, homemaking, giving medication, or acting as a companion or sitter* • *Services provided by a nurse, nursing assistant, health aide, or other similarly licensed or unlicensed person that are billed by a skilled nursing facility, extended care facility, or nursing home, except as included in the benefits described on page 85* • *Private duty nursing*	*All charges*	*All charges*

Manipulative treatment	You Pay	
	Standard Option	Basic Option
Manipulative treatment performed by a Doctor of Osteopathy (D.O.), Doctor of Medicine (M.D.), or Doctor of Chiropractic (D.C.) when the provider is practicing within the scope of his/her license, limited to: • Osteopathic manipulative treatment to any body region • Chiropractic spinal and/or extraspinal manipulative treatment ***Note:*** Benefits for manipulative treatment are limited to the services and combined treatment visits stated here.	Preferred: $20 copayment per visit (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** Benefits for osteopathic and chiropractic manipulative treatment are limited to a combined total of 12 visits per person, per calendar year. ***Note:*** Manipulation visits that you pay for while meeting your calendar year deductible count toward the treatment limit cited above.	Preferred: $25 copayment per visit ***Note:*** Benefits for osteopathic and chiropractic manipulative treatment are limited to a combined total of 20 visits per person, per calendar year. Participating/Non-participating: You pay all charges
Alternative treatments		
Acupuncture ***Note:*** Acupuncture must be performed and billed by a medical practitioner who is licensed or certified to perform acupuncture by the state where the services are provided, and who is acting within the scope of that license or certification. See page 18 for more information. ***Note:*** See page 76 for our coverage of acupuncture when provided as anesthesia for covered surgery. ***Note:*** See page 46 for our coverage of acupuncture when provided as anesthesia for covered maternity care.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** Benefits for acupuncture are limited to 24 visits per calendar year. ***Note:*** Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $35 copayment per visit ***Note:*** Benefits for acupuncture are limited to 10 visits per calendar year. ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
Not covered: • *Biofeedback* • *Self-care or self-help training*	*All charges*	*All charges*

Educational classes and programs	You Pay	
	Standard Option	Basic Option
• Smoking and tobacco cessation treatment • Individual counseling for smoking and tobacco use cessation ***Note:*** Benefits are not available for group counseling. • Smoking and tobacco cessation classes ***Note:*** See Section 5(f) for our coverage of smoking and tobacco cessation drugs.	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
• Diabetic education ***Note:*** See pages 42 and 45 for our coverage of nutritional counseling services that are not part of a diabetic education program.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $25 copayment per visit Preferred specialist: $35 copayment per visit Participating/Non-participating: You pay all charges
Not covered: • *Marital, family, educational, or other counseling or training services when performed as part of an educational class or program* • *Premenstrual syndrome (PMS), lactation (except as described on page 46), headache, eating disorder (except as described on pages 42 and 45), and other educational clinics* • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Services performed or billed by a school or halfway house or a member of its staff* • *Applied behavior analysis (ABA) or ABA therapy*	*All charges*	*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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service.
- The amounts listed in this Section are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL for the following surgical services if they are to be performed on an outpatient basis: surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 23 for more information.**
- **YOU MUST GET PRIOR APPROVAL for all organ transplant surgical procedures (except kidney and cornea transplants); and if your surgical procedure requires an inpatient admission, YOU MUST GET PRECERTIFICATION. Please refer to the prior approval and precertification information shown in Section 3 to be sure which services require prior approval or precertification.**
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
  - The calendar year deductible is $350 per person ($700 per family).
  - We provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our payment and the billed amount.
  - You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 24 for more information.
- **Under Basic Option,**
  - There is **no calendar year deductible**.
  - **You must use Preferred providers in order to receive benefits. See below and page 21 for the exceptions to this requirement.**
  - We provide benefits at Preferred benefit levels for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our payment and the billed amount.

Benefit Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Surgical procedures	**Standard Option**	**Basic Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures and dislocations, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Colonoscopy (with or without biopsy) to diagnose or treat a specific condition ***Note:*** See page 42 for our coverage of screening colonoscopies billed for by a physician or other covered health care professional. • Endoscopic procedures • Injections • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery* on page 66) • Treatment of burns • Circumcision of newborn • Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic devices, and Section 5(c) – Other hospital services and supplies – for our coverage for the device. • Voluntary sterilization for men (vasectomy) ***Note:*** See page 48 for our coverage of voluntary sterilization procedures for women. • Assistant surgeons/surgical assistance if required because of the complexity of the surgical procedures • Gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures to treat morbid obesity – a condition in which an individual has a Body Mass Index (BMI) of 40 or more, or an individual with a BMI of 35 or more with one or more co-morbidities; eligible members must be age 18 or over ***Note:*** **Benefits for the surgical treatment of morbid obesity are subject to the requirements listed on page 64.**	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 24 for more information.	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about "agents.") Participating/Non-participating: You pay all charges

Surgical procedures – continued on next page

Surgical procedures *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Note: **Prior approval is required for outpatient surgery for morbid obesity.** For more information about prior approval, please refer to page 23. • Benefits for the surgical treatment of morbid obesity, performed on an inpatient or outpatient basis, are subject to the pre-surgical requirements listed below. **The member must meet all requirements.** – Diagnosis of morbid obesity (as defined on page 63) for a period of 2 years prior to surgery – Participation in a medically supervised weight loss program, including nutritional counseling, for at least 3 months prior to the date of surgery. (***Note:*** Benefits are not available for commercial weight loss programs; see page 42 for our coverage of nutritional counseling services.) – Pre-operative nutritional assessment and nutritional counseling about pre- and post-operative nutrition, eating, and exercise – Evidence that attempts at weight loss in the 1 year period prior to surgery have been ineffective – Psychological clearance of the member's ability to understand and adhere to the pre- and post-operative program, based on a psychological assessment performed by a licensed professional mental health practitioner (see page 95 for our payment levels for mental health services) – Member has not smoked in the 6 months prior to surgery – Member has not been treated for substance abuse for 1 year prior to surgery and there is no evidence of substance abuse during the 1-year period prior to surgery • Benefits for subsequent surgery for morbid obesity, performed on an inpatient or outpatient basis, are subject to the following additional pre-surgical requirements: – All criteria listed above for the initial procedure must be met again – Previous surgery for morbid obesity was at least 2 years prior to repeat procedure – Weight loss from the initial procedure was less than 50% of the member's excess body weight at the time of the initial procedure – Member complied with previously prescribed post-operative nutrition and exercise program • Claims for the surgical treatment of morbid obesity must include documentation from the member's provider(s) that all pre-surgical requirements have been met.		

Surgical procedures – continued on next page

Surgical procedures *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Note: When multiple surgical procedures that add time or complexity to patient care are performed during the same operative session, the Local Plan determines our allowance for the combination of multiple, bilateral, or incidental surgical procedures. Generally, we will allow a reduced amount for procedures other than the primary procedure. ***Note:*** We do not pay extra for "incidental" procedures (those that do not add time or complexity to patient care). ***Note:*** When unusual circumstances require the removal of casts or sutures by a physician other than the one who applied them, the Local Plan may determine that a separate allowance is payable.		
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby physician* • *Routine surgical treatment of conditions of the foot [see Section 5(a)* – Foot care*]* • *Cosmetic surgery* • *LASIK, INTACS, radial keratotomy, and other refractive surgery*	*All charges*	*All charges*

Reconstructive surgery	You Pay	
	Standard Option	Basic Option
• Surgery to correct a functional defect • Surgery to correct a congenital anomaly – a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. ***Note:*** Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth. ***Note:*** **You must get prior approval for outpatient surgical correction of congenital anomalies.** Please refer to page 23 for more information. • Treatment to restore the mouth to a pre-cancer state • All stages of breast reconstruction surgery following a mastectomy, such as: – Surgery to produce a symmetrical appearance of the patient's breasts – Treatment of any physical complications, such as lymphedemas ***Note:*** Internal breast prostheses are paid as orthopedic and prosthetic devices [see Section 5(a)]. See Section 5(c) when billed by a facility. ***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. • Surgery for placement of penile prostheses to treat erectile dysfunction	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 24 for more information.	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about "agents.") Participating/Non-participating: You pay all charges
Not covered: • *Cosmetic surgery – any operative procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form – unless required for a congenital anomaly or to restore or correct a part of the body that has been altered as a result of accidental injury, disease, or surgery (does not include anomalies related to the teeth or structures supporting the teeth)* • *Surgeries related to sex transformation, sexual dysfunction, or sexual inadequacy, except as specifically shown above*	*All charges*	*All charges*

Oral and maxillofacial surgery	You Pay	
	Standard Option	**Basic Option**
Oral surgical procedures, limited to: • Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is necessary • Surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth ***Note:* You must get prior approval for outpatient surgery needed to correct accidental injuries as described above.** Please refer to page 23 for more information. • Excision of exostoses of jaws and hard palate • Incision and drainage of abscesses and cellulitis • Incision and surgical treatment of accessory sinuses, salivary glands, or ducts • Reduction of dislocations and excision of temporomandibular joints • Removal of impacted teeth ***Note:*** Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 24 for more information.	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 141 for more information about "agents.") Participating/Non-participating: You pay all charges
Not covered: • *Oral implants and transplants except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Surgical procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Surgical procedures involving dental implants or preparation of the mouth for the fitting or the continued use of dentures, except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Orthodontic care before, during, or after surgery, except for orthodontia associated with surgery to correct accidental injuries as specifically described above and in Section 5(g)*	*All charges*	*All charges*

Organ/tissue transplants	You Pay	
	Standard Option	Basic Option
Solid organ transplants (see list in the next box below) are subject to medical necessity and experimental/ investigational review. Refer to *Other services* in Section 3 (see page 23) for prior approval procedures. **Prior approval requirements:** You must obtain prior approval (see page 23) from the Local Plan, for both the procedure and the facility, for the following transplant procedures: • Blood or marrow stem cell transplant procedures ***Note:*** See pages 72 and 73 for services related to blood or marrow stem cell transplants covered under clinical trials. • Autologous pancreas islet cell transplant • Heart • Heart-lung • Intestinal transplants (small intestine with or without other organs) • Liver • Lung (single, double, or lobar) • Pancreas • Simultaneous liver-kidney • Simultaneous pancreas-kidney ***Note:*** Refer to pages 24-25 for information about precertification of inpatient care.		
Solid organ transplants are limited to: • Cornea • Kidney • Heart • Liver • Heart-lung • Pancreas • Simultaneous pancreas-kidney • Simultaneous liver-kidney • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Single, double, or lobar lung • For members with end-stage cystic fibrosis, benefits for lung transplantation are limited to double lung transplants	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** You may request prior approval and receive specific benefit information in advance for kidney and cornea transplants to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 24 for more information.	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	You Pay	
	Standard Option	Basic Option
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. Physicians consider many features to determine how diseases will respond to different types of treatments. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Myeloablative allogeneic blood or marrow stem cell transplants for: – Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia – Chronic myelogenous leukemia – Hemoglobinopathy (i.e., Sickle cell anemia, Thalassemia major) – High-risk neuroblastoma – Hodgkin's lymphoma – Infantile malignant osteopetrosis – Inherited metabolic disorders (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy, Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) – Marrow failure [i.e., severe or very severe aplastic anemia, Fanconi's Anemia, Paroxysmal nocturnal hemoglobinuria (PNH), pure red cell aplasia, congenital thrombocytopenia] – MDS/MPN [e.g., Chronic myelomonocytic leukemia (CMML)] – Myelodysplasia/Myelodysplastic syndromes (MDS) – Myeloproliferative neoplasms (MPN) (e.g., Polycythemia vera, Essential thrombocythemia, Primary myelofibrosis) – Non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) – Primary Immunodeficiencies (e.g., Severe combined immunodeficiency, Wiskott-Aldrich syndrome, hemophagocytic lymphohistiocytosis, X-linked lymphoproliferative syndrome, Kostmann's syndrome, Leukocyte adhesion deficiencies)	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	You Pay	
	Standard Option	Basic Option
Blood or marrow stem cell transplants limited to the stages of the following diagnoses *(continued from page 69)*. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Myeloablative allogeneic blood or marrow stem cell transplants limited to the following diagnoses **only when performed in a Blue Distinction Centers for Transplants facility**. You must obtain prior approval of these transplant procedures from the Local Plan. – Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – Plasma Cell Disorders [e.g., Multiple Myeloma; Amyloidosis; Polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes (POEMS) syndrome] • Reduced-intensity conditioning (RIC) nonmyeloablative allogeneic blood or marrow stem cell transplants limited to the following diagnoses, **only when performed in a Blue Distinction Centers for Transplants facility**. You must obtain prior approval of these transplant procedures from the Local Plan. – Acute non-lymphocytic (myelogenous) leukemia/acute lymphocytic leukemia – Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) with poor response to therapy; short time to progression; transformed disease; or high risk disease – Chronic myelogenous leukemia – Hemoglobinopathy (Sickle-cell anemia, Thalassemia major) – Hodgkin's lymphoma – Infantile malignant osteopetrosis – Inherited Metabolic disorders (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy, Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) – Marrow failure [severe or very severe aplastic anemia, Fanconi's Anemia, Paroxysmal nocturnal hemoglobinuria (PNH), pure red cell aplasia, congenital thrombocytopenia] – MDS/MPN [e.g., chronic myelomonocytic leukemia (CMML)] – Myelodysplasia/myelodysplastic syndromes (MDS)	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	You Pay	
	Standard Option	Basic Option
Blood or marrow stem cell transplants limited to the stages of the following diagnoses *(continued from page 70)*. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Reduced-intensity conditioning (RIC) nonmyeloablative allogeneic blood or marrow stem cell transplants limited to the following diagnoses, **only when performed in a Blue Distinction Centers for Transplants facility**. You must obtain prior approval of these transplant procedures from the Local Plan *(continued from page 70).* – Myeloproliferative neoplasms (MPN) (e.g., Polycythemia vera, Essential thrombocythemia, Primary myelofibrosis) – Non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) – Plasma Cell Disorders [e.g., Multiple Myeloma; Amyloidosis; Polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes (POEMS) syndrome] – Primary Immunodeficiencies (Severe combined immunodeficiency, Wiskott-Aldrich syndrome, Hemophagocytic lymphohistiocytosis, X-linked lymphoproliferative syndrome, Kostmann's syndrome, Leukocyte adhesion deficiencies) • Autologous blood or marrow stem cell transplants for: – Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia – Central Nervous System (CNS) Embryonal tumors [e.g., atypical teratoid/rhabdoid tumor, primitive neuroectodermal tumors (PNETs), medulloblastoma, pineoblastoma, ependymoblastoma] – Ewing's sarcoma – Germ cell tumors – High-risk neuroblastoma – Hodgkin's lymphoma – Non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) – Plasma Cell Disorders [e.g., Multiple Myeloma; Amyloidosis; Polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes (POEMS) syndrome]	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
(1) For the following blood or marrow stem cell transplant procedures, we provide benefits **only** when conducted at a Cancer Research Facility, a Blue Distinction Centers for Transplants facility, or a Foundation for the Accreditation of Cellular Therapy (FACT) accredited facility (see pages 20 and 21) and only when performed as part of a clinical trial that meets the **requirements** listed on page 73: Nonmyeloablative (reduced-intensity conditioning or RIC) allogeneic blood or marrow stem cell transplants for: – Breast cancer – Colon cancer – Glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme) – Epidermolysis bullosa – Ovarian cancer – Prostate cancer – Renal cell carcinoma – Retinoblastoma – Rhabdomyosarcoma – Sarcoma – Wilm's Tumor Autologous blood or marrow stem cell transplants for: – Breast cancer – Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – Chronic myelogenous leukemia – Epithelial ovarian cancer – Glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme) – Retinoblastoma – Rhabdomyosarcoma – Wilm's Tumor ***Note:*** If a non-randomized clinical trial for a blood or marrow stem cell transplant listed above meeting the **requirements** shown on page 73 is not available, we will arrange for the transplant to be provided at an approved transplant facility, if available.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
(2) For the following procedures, we provide benefits **only** when conducted at a FACT-accredited facility (see page 21) and only when performed as part of a clinical trial that meets the **requirements** listed below: Nonmyeloablative (reduced-intensity conditioning or RIC) allogeneic blood or marrow stem cell transplants or autologous blood or marrow stem cell transplants for: – Autoimmune disease (e.g., Multiple sclerosis, Scleroderma, Systemic lupus erythematosus, Chronic inflammatory demyelinating polyneuropathy) (3) **Requirements** for blood or marrow stem cell transplants covered under clinical trials: For these blood or marrow stem cell transplant procedures and related services or supplies covered only through clinical trials: • You must contact us at the customer service number listed on the back of your ID card to obtain prior approval (see page 23); • The clinical trial must be reviewed and approved by the Institutional Review Board of the Cancer Research Facility or FACT-accredited facility where the procedure is to be delivered; and • The patient must be properly and lawfully registered in the clinical trial, meeting all the eligibility requirements of the trial. ***Note:*** Clinical trials are research studies in which physicians and other researchers work to find ways to improve care. Each study tries to answer scientific questions and to find better ways to prevent, diagnose, or treat patients. A clinical trial has possible benefits as well as risks. Each trial has a protocol which explains the purpose of the trial, how the trial will be performed, who may participate in the trial, and the beginning and end points of the trial. Information regarding clinical trials is available at www.cancer.gov. Even though we may state benefits are available for a specific type of clinical trial, you may not be eligible for inclusion in these trials or there may not be any trials available in a Cancer Research Facility or FACT-accredited facility to treat your condition at the time you seek to be included in a clinical trial. If your physician has recommended you participate in a clinical trial, we encourage you to contact the Case Management Department at your Local Plan for assistance. ***Note:*** See page 134 for our coverage of other costs associated with clinical trials.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Related transplant services: • Extraction or reinfusion of blood or marrow stem cells as part of a covered allogeneic or autologous blood or marrow stem cell transplant • Harvesting, immediate preservation, and storage of stem cells when the autologous blood or marrow stem cell transplant has been scheduled or is anticipated to be scheduled within an appropriate time frame for patients diagnosed at the time of harvesting with one of the conditions listed on pages 69-73 ***Note:*** Benefits are available for charges related to fees for storage of harvested autologous blood or marrow stem cells related to a covered autologous stem cell transplant that has been scheduled or is anticipated to be scheduled within an appropriate time frame. No benefits are available for any charges related to fees for long term storage of stem cells. • Collection, processing, storage, and distribution of cord blood only when provided as part of a blood or marrow stem cell transplant scheduled or anticipated to be scheduled within an appropriate time frame for patients diagnosed with one of the conditions listed on pages 69-73 • Related medical and hospital expenses of the donor, when we cover the recipient • Related services or supplies provided to the recipient • Donor screening tests for up to three non-full sibling (such as unrelated) potential donors, for any full sibling potential donors, and for the actual donor used for transplant ***Note:*** See Section 5(a) for coverage for related services, such as chemotherapy and/or radiation therapy and drugs administered to stimulate or mobilize stem cells for covered transplant procedures.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*

Organ/Tissue Transplants at Blue Distinction Centers for Transplants®

We participate in the Blue Distinction Centers for Transplants program for the organ/tissue transplants listed below. You will receive enhanced benefits if you use a Blue Distinction Centers for Transplants facility (see pages 20-21 for more information).

All members (including those who have Medicare Part A or another group health insurance policy as their primary payor) must contact us at the customer service number listed on the back of their ID card before obtaining services. You will be referred to the designated Plan transplant coordinator for information about Blue Distinction Centers for Transplants.

- Heart
- Liver
- Pancreas (pancreas transplant alone, pancreas after kidney, simultaneous pancreas-kidney)
- Single or double lung
- Blood or marrow stem cell transplants listed on pages 69-73
- Related transplant services listed on page 74

Note: Benefits for cornea, kidney-only, and intestinal transplants are not available through Blue Distinction Centers for Transplants. See page 68 for benefit information for these transplants.

Note: See Section 5(c) for our benefits for facility care.

Note: Members will not be responsible for separate cost-sharing for the included professional services (see pages 20-21).

Note: See pages 69-74 for requirements related to blood or marrow stem cell transplant coverage.

Note: See pages 20-21 for special instructions regarding all admissions to Blue Distinction Centers for Transplants.

Organ/tissue transplants *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Not covered: • *Transplants for any diagnosis not listed as covered* • *Donor screening tests and donor search expenses, except as defined on page 74* • *Implants of artificial organs, including those implanted as a bridge to transplant and/or as destination therapy*	*All charges*	*All charges*

Anesthesia	You Pay	
	Standard Option	Basic Option
Anesthesia (including acupuncture) for covered medical or surgical services when requested by the attending physician and performed by: • A certified registered nurse anesthetist (CRNA), or • A physician other than the physician (or the assistant) performing the covered medical or surgical procedure Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Anesthesia services consist of administration by injection or inhalation of a drug or other anesthetic agent (including acupuncture) to obtain muscular relaxation, loss of sensation, or loss of consciousness. ***Note:*** See Section 5(c) for our payment levels for anesthesia services billed by a facility.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3 to be sure which services require precertification.
- ***Note:*** **Observation services** are billed as outpatient facility care. As a result, benefits for observation services are provided at the outpatient facility benefit levels described on page 81. See page 145 for more information about these types of services.
- **YOU MUST GET PRIOR APPROVAL for the following surgical services if they are to be performed on an outpatient basis: surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 23 for more information.**
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a physician, a physical therapist, or an outpatient facility.
- The amounts listed in this Section are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service, for your inpatient or outpatient surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are listed in Sections 5(a) or 5(b).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
  - The calendar year deductible is $350 per person ($700 per family).
- **Under Basic Option,**
  - There is **no calendar year deductible.**
  - **You must use Preferred providers in order to receive benefits.** See page 21 for the exceptions to this requirement.
  - Your cost-share for care performed and billed by Preferred professional providers in the outpatient department of a Preferred hospital is waived for services other than surgical services, drugs, supplies, orthopedic and prosthetic devices, and durable medical equipment. You are responsible for the applicable cost-sharing amount(s) for the services performed and billed by the hospital.

Benefit Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Inpatient hospital	**Standard Option**	**Basic Option**
Room and board, such as: • Semiprivate or intensive care accommodations • General nursing care • Meals and special diets ***Note:*** We cover a private room only when you must be isolated to prevent contagion, when your isolation is required by law, or when a Preferred or Member hospital only has private rooms. If a Preferred or Member hospital only has private rooms, we base our payment on the contractual status of the facility. If a Non-member hospital only has private rooms, we base our payment on the Plan allowance for your type of admission. Please see page 145 for more information.	Preferred: $250 per admission copayment for unlimited days (no deductible) Member: $350 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member: $350 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment ***Note:*** If you are admitted to a Member or Non-member facility due to a **medical emergency or accidental injury**, you pay a $350 per admission copayment for unlimited days and we then provide benefits at 100% of the Plan allowance.	Preferred: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member: You pay all charges

Inpatient hospital – continued on next page

Inpatient hospital *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs • Diagnostic studies, radiology services, laboratory tests, and pathology services • Administration of blood or blood plasma • Dressings, splints, casts, and sterile tray services • Internal prosthetic devices • Other medical supplies and equipment, including oxygen • Anesthetics and anesthesia services • Take-home items • Pre-admission testing recognized as part of the hospital admissions process • Nutritional counseling • Acute inpatient rehabilitation ***Note:*** **Observation services** are billed as outpatient facility care. As a result, benefits for observation services are provided at the outpatient facility benefit levels described on page 81. See page 145 for more information about these types of services. ***Note:*** Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 26 for other circumstances, such as extended stays for you or your baby. • If you need to stay longer in the hospital than initially planned, we will cover an extended stay if it is medically necessary. However, you must precertify the extended stay. See Section 3 for information on requesting additional days. • We pay inpatient hospital benefits for an admission in connection with the treatment of children up to age 22 with severe dental caries. We cover hospitalization for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. We provide benefits for dental procedures as shown in Section 5(g). ***Note:*** See pages 46-47 for other covered maternity services. ***Note:*** See page 58 for coverage of blood and blood products.	Preferred: $250 per admission copayment for unlimited days (no deductible) ***Note:*** For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use a Preferred facility. Member: $350 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member: $350 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred: $175 per day copayment up to $875 per admission for unlimited days ***Note:*** For Preferred facility care related to maternity (including inpatient facility care, care at birthing facilities, and services you receive on an outpatient basis), your responsibility for the covered services you receive is limited to $175 per admission. Member/Non-member: You pay all charges

Inpatient hospital – continued on next page

Inpatient hospital *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Not covered: • *Admission to noncovered facilities, such as nursing homes, extended care facilities, schools, residential treatment centers* • *Personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services* • *Private duty nursing* *Hospital room and board expenses when, in our judgment, a hospital admission or portion of an admission is:* • *Custodial or long term care (see Definitions)* • *Convalescent care or a rest cure* • *Domiciliary care provided because care in the home is not available or is unsuitable* • *Not medically necessary, such as when services did not require the acute hospital inpatient (overnight) setting but could have been provided safely and adequately in a physician's office, the outpatient department of a hospital, or some other setting, without adversely affecting your condition or the quality of medical care you receive. Some examples are:* – *Admissions for, or consisting primarily of, observation and/or evaluation that could have been provided safely and adequately in some other setting (such as a physician's office)* – *Admissions primarily for diagnostic studies, radiology services, laboratory tests, or pathology services that could have been provided safely and adequately in some other setting (such as the outpatient department of a hospital or a physician's office)* ***Note:*** *If we determine that a hospital admission is one of the types listed above, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting. Benefits are limited to care provided by covered facility providers (see pages 18-21).*	*All charges*	*All charges*

Outpatient hospital or ambulatory surgical center	You Pay	
	Standard Option	Basic Option
Outpatient **surgical and treatment services** performed and billed by a hospital or freestanding ambulatory facility, such as: • Operating, recovery, and other treatment rooms • Anesthetics and anesthesia services • Pre-surgical testing performed within one business day of the covered surgical services • Observation services ***Note:*** Observation services are billed as outpatient facility care. As a result, benefits for observation services are provided at the outpatient facility benefit levels described on this page. See page 145 for more information about these types of services. • Chemotherapy and radiation therapy • Colonoscopy (with or without biopsy) to diagnose or treat a specific condition ***Note:*** See page 42 for our coverage of screening colonoscopies. • Intravenous (IV)/infusion therapy • Renal dialysis • Visits to the outpatient department of a hospital for non-emergency treatment services • Diabetic education • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced, and other biologicals • Dressings, splints, casts, and sterile tray services • Facility supplies for hemophilia home care • Other medical supplies, including oxygen ***Note:*** See pages 90-93 for our payment levels for care related to a medical emergency or accidental injury. ***Note:*** See pages 48-49 for our coverage of family planning services. ***Note:*** For our coverage of hospital-based clinic visits, please refer to the professional benefits described on page 37.	Preferred facilities: 15% of the Plan allowance (deductible applies) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred: $100 copayment per day per facility (except as noted below) ***Note:*** You may be responsible for paying a $150 copayment per day per facility if other diagnostic services are billed in addition to the services listed here. ***Note:*** You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 141 for more information about "agents.") Member/Non-member: You pay all charges

Outpatient hospital or ambulatory surgical center – continued on next page

Outpatient hospital or ambulatory surgical center *(continued)*	You Pay	
	Standard Option	Basic Option
Note: For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility. See pages 46-47 for other included maternity services. ***Note:*** See page 84 for outpatient drugs, medical devices, and durable medical equipment billed for by a hospital or freestanding ambulatory facility. ***Note:*** We cover outpatient hospital services and supplies related to the treatment of children up to age 22 with severe dental caries. We cover outpatient care related to other types of dental procedures only when a non-dental physical impairment exists that makes the hospital setting necessary to safeguard the health of the patient. See Section 5(g), *Dental benefits*, for additional benefit information.		
Outpatient **diagnostic testing and treatment services** performed and billed by a hospital or freestanding ambulatory facility, limited to: • Angiographies • Bone density tests • CT scans/MRIs/PET scans • Genetic testing • Nuclear medicine • Sleep studies	Preferred facilities: 15% of the Plan allowance (deductible applies) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred: $150 copayment per day per facility Member: $150 copayment per day per facility Non-member: $150 copayment per day per facility, plus any difference between our allowance and the billed amount ***Note:*** You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 141 for more information about "agents.")
Outpatient **diagnostic testing services** performed and billed by a hospital or freestanding ambulatory facility, including but not limited to: • EEGs • Ultrasounds • Neurological testing • X-rays (including set-up of portable X-ray equipment) ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.	Preferred facilities: 15% of the Plan allowance (deductible applies) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred: $40 copayment per day per facility Member: $40 copayment per day per facility Non-member: $40 copayment per day per facility, plus any difference between our allowance and the billed amount ***Note:*** You may be responsible for paying a higher copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here. ***Note:*** You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 141 for more information about "agents.")

Outpatient hospital or ambulatory surgical center – continued on next page

Outpatient hospital or ambulatory surgical center *(continued)*	You Pay	
	Standard Option	**Basic Option**
Outpatient **treatment services** performed and billed by a hospital or freestanding ambulatory facility, limited to: Cardiac rehabilitation Cognitive rehabilitation Pulmonary rehabilitation Physical, occupational, and speech therapy	Preferred facilities: 15% of the Plan allowance (deductible applies) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount. ***Note:*** See page 52 for our coverage of physical, occupational, and speech therapy.	Preferred: $25 copayment per day per facility ***Note:*** You may be responsible for paying a higher copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here. ***Note:*** You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 141 for more information about "agents.") ***Note:*** Benefits are limited to a total of 50 visits per person, per calendar year for outpatient physical, occupational, or speech therapy, or a combination of all three, regardless of the type of covered provider billing for the services. Member/Non-member: You pay all charges
Outpatient **diagnostic and treatment services** performed and billed by a hospital or freestanding ambulatory facility, limited to: • Laboratory tests and pathology services • EKGs ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.	Preferred facilities: 15% of the Plan allowance (deductible applies) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred: Nothing Member: Nothing Non-member: You pay any difference between our allowance and the billed amount ***Note:*** You may be responsible for paying a copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here. ***Note:*** You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 141 for more information about "agents.")

Outpatient hospital or ambulatory surgical center – continued on next page

Outpatient hospital or ambulatory surgical center *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Outpatient **adult preventive care** performed and billed by a hospital or freestanding ambulatory facility, limited to: • Visits/exams for preventive care and screening procedures described on pages 41-44 • Cancer screenings listed on page 42 and ultrasound screening for aortic abdominal aneurysm ***Note:*** See page 45 for our payment levels for covered preventive care services for children billed for by facilities and performed on an outpatient basis.	See pages 41-44 for our payment levels for covered preventive care services for adults	Preferred: Nothing ***Note:*** See page 41 for our payment levels for visits/exams for preventive care. Member/Non-member: Nothing for cancer screenings and ultrasound screening for aortic abdominal aneurysm ***Note:*** Benefits are not available for routine adult physical examinations, associated laboratory tests, screening colonoscopies, or routine immunizations performed at Member or Non-member facilities.
Outpatient **drugs, medical devices, and durable medical equipment** billed for by a hospital or freestanding ambulatory facility, such as: • Prescribed drugs • Orthopedic and prosthetic devices • Durable medical equipment ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.	Preferred facilities: 15% of the Plan allowance (deductible applies) Member/Non-member facilities: 35% of the Plan allowance (deductible applies)	Preferred: 30% of the Plan allowance ***Note:*** You may also be responsible for paying a copayment per day per facility for outpatient services. See above and pages 81-83 for specific coverage information. Member/Non-member: You pay all charges

Extended care benefits/Skilled nursing care facility benefits	You Pay	
	Standard Option	Basic Option
Limited to the following benefits for Medicare Part A copayments: When Medicare Part A is the primary payor (meaning that it pays first) and has made payment, **Standard Option** provides limited secondary benefits. We pay the applicable Medicare Part A copayments incurred **in full** during the first through the 30th day of confinement for each benefit period (as defined by Medicare) in a qualified skilled nursing facility. A qualified skilled nursing facility is a facility that specializes in skilled nursing care performed by or under the supervision of licensed nurses, skilled rehabilitation services, and other related care, and meets Medicare's special qualifying criteria, but is not an institution that primarily cares for and treats mental diseases. If Medicare pays the first 20 days in full, Plan benefits will begin on the 21st day (when Medicare Part A copayments begin) and will end on the 30th day. ***Note:*** See page 52 for benefits provided for outpatient physical, occupational, speech, and cognitive rehabilitation therapy when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs. ***Note:*** **If you do not have Medicare Part A, we do not provide benefits for skilled nursing facility care.**	Preferred: Nothing (no deductible) Participating/Member: Nothing (no deductible) Non-participating/Non-member: Nothing (no deductible) ***Note:*** You pay all charges not paid by Medicare after the 30th day.	*All charges*

Hospice care	You Pay	
	Standard Option	Basic Option
Hospice care is an integrated set of services and supplies designed to provide palliative and supportive care to members with a projected life expectancy of six (6) months or less due to a terminal medical condition, as certified by the member's primary care provider or specialist.	See below and pages 87-88	See below and pages 87-88
Pre-Hospice Enrollment Benefits **Prior approval is not required.** Before home hospice care begins, members may be evaluated by a physician to determine if home hospice care is appropriate. We provide benefits for pre-enrollment visits when provided by a physician who is employed by the home hospice agency and when billed by the agency employing the physician. The pre-enrollment visit includes services such as: • Evaluating the member's need for pain and/or symptom management; and • Counseling regarding hospice and other care options	Nothing (no deductible)	Nothing
Prior approval from the Local Plan is required for all hospice services. Our prior approval decision will be based on the medical necessity of the hospice treatment plan and the clinical information provided to us by the primary care provider (or specialist) and the hospice provider. We may also request information from other providers who have treated the member. All hospice services must be billed by the approved hospice agency. **You are responsible for making sure the hospice care provider has received prior approval from the Local Plan** (see page 23 for instructions). Please check with your Local Plan, and/or go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder, for listings of Preferred hospice providers. ***Note:*** If Medicare Part A is the primary payor for the member's hospice care, prior approval is not required. However, our benefits will be limited to those services listed above and on pages 87 and 88. **Members with a terminal medical condition (or those acting on behalf of the member) are encouraged to contact the Case Management Department at their Local Plan for information about hospice services and Preferred hospice providers.**		

Hospice care – continued on next page

Hospice care *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Covered services We provide benefits for the hospice services listed below when the services have been included in an approved hospice treatment plan and are provided by the home hospice program in which the member is enrolled: • Nursing care • Periodic physician visits • Dietary counseling • Durable medical equipment rental • Medical social services • Medical supplies • Oxygen therapy • Physical therapy, occupational therapy, and speech therapy related to the terminal medical condition • Prescription drugs • Services of home health aides (certified or licensed, if the state requires it, and provided by the home hospice agency)	See below	See below
Traditional Home Hospice Care Periodic visits to the member's home for the management of the terminal medical condition and to provide limited patient care in the home. See page 86 for prior approval requirements.	Nothing (no deductible)	Nothing
Continuous Home Hospice Care Services provided in the home to members enrolled in home hospice during a period of crisis, such as frequent medication adjustments to control symptoms or to manage a significant change in the member's condition, requiring a minimum of 8 hours of care during each 24-hour period by a registered nurse (R.N.) or licensed practical nurse (L.P.N.). ***Note:*** Members must receive prior approval from the Local Plan for each episode of continuous home hospice care (see page 86). An episode consists of up to seven (7) consecutive days of continuous care. Each episode must be separated by at least 21 days of traditional home hospice care. The member must be enrolled in a home hospice program and the continuous home hospice care services must be provided by the home hospice program in which the member is enrolled.	Preferred: $250 per episode copayment (no deductible) Member: $350 per episode copayment (no deductible) Non-member: $350 per episode copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred: $150 per day copayment up to $750 maximum per episode Member/Non-member: You pay all charges

Hospice care – continued on next page

Hospice care *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Inpatient Hospice Care Benefits are available for inpatient hospice care when provided by a facility that is licensed as an inpatient hospice facility and when: • Inpatient services are necessary to control pain and/or manage the member's symptoms; • Death is imminent; or • Inpatient services are necessary to provide an interval of relief (respite) to the caregiver ***Note:*** Benefits are provided for up to thirty (30) consecutive days in a facility licensed as an inpatient hospice facility. Each inpatient stay must be separated by at least 21 days of traditional home hospice care. The member does not have to be enrolled in a home hospice care program to be eligible for the first inpatient stay. However, the member must be enrolled in a home hospice care program in order to receive benefits for subsequent inpatient stays.	Preferred: Nothing (no deductible) Member: $350 per admission copayment, plus 35% of the Plan allowance (no deductible) Non-member: $350 per admission copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred: Nothing Member/Non-member: You pay all charges
Not covered: • *Homemaker services* • *Home hospice care (e.g., care given by a home health aide) that is provided and billed for by other than the approved home hospice agency when the same type of care is already being provided by the home hospice agency*	*All charges*	*All charges*

Ambulance	You Pay	
	Standard Option	Basic Option
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and: • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required.	Preferred: $100 copayment per day for ground ambulance transport services (no deductible) Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services (no deductible) ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required.	Preferred: Nothing (no deductible) Participating/Member or Non-participating/Non-member: Nothing (no deductible) ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.
Not covered: • *Wheelchair van services and gurney van services* • *Ambulance and any other modes of transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests not associated with covered inpatient hospital care*	*All charges*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
  - The calendar year deductible is $350 per person ($700 per family).
- **Under Basic Option,**
  - There is **no calendar year deductible**.
  - **You must use Preferred providers in order to receive benefits, except in cases of medical emergency or accidental injury. Refer to the guidelines appearing below for additional information.**

What is an accidental injury?

An accidental injury is an injury caused by an external force or element such as a blow or fall and which requires immediate medical attention, including animal bites and poisonings. [See Section 5(g) for dental care for accidental injury.]

What is a medical emergency?

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

Basic Option benefits for emergency care

Under Basic Option, you are encouraged to seek care from Preferred providers in cases of accidental injury or medical emergency. However, if you need care immediately and cannot access a Preferred provider, we will provide benefits for the **initial** treatment provided in the emergency room of any hospital – even if the hospital is not a Preferred facility. We will also provide benefits if you are admitted directly to the hospital from the emergency room until your condition has been stabilized. In addition, we will provide benefits for emergency ambulance transportation provided by Preferred or Non-preferred ambulance providers if the transport is due to a medical emergency or accidental injury.

We provide emergency benefits when you have acute symptoms of sufficient severity – including severe pain – such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child.

Benefit Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Accidental injury	**Standard Option**	**Basic Option**
• **Physician services** in the hospital outpatient department, urgent care center, or physician's office, including diagnostic studies, radiology services, laboratory tests, and pathology services • Related outpatient **hospital services** and supplies, including diagnostic studies, radiology services, laboratory tests, and pathology services ***Note:*** We pay Inpatient professional and hospital benefits if you are admitted [see Sections 5(a), 5(b), and 5(c)]. ***Note:*** See Section 5(g) for dental benefits for accidental injuries.	Preferred: Nothing (no deductible) Participating/Member: Nothing (no deductible) Non-participating/Non-member: Any difference between the Plan allowance and the billed amount (no deductible) ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, regular medical and outpatient hospital benefits apply. See Section 5(a), Medical services and supplies, Section 5(b), Surgical procedures, and Section 5(c), Outpatient hospital, for the benefits we provide. ***Note:*** For drugs, services, supplies, and/or durable medical equipment billed by a provider other than a hospital, urgent care center, or physician, see Sections 5(a) and 5(f) for the benefit levels that apply.	Preferred urgent care center: $50 copayment per visit Participating/Non-participating urgent care center: You pay all charges Preferred emergency room: $125 copayment per visit Participating/Member emergency room: $125 copayment per visit Non-participating/Non-member emergency room: $125 copayment per visit, plus any difference between our allowance and the billed amount ***Note:*** If you are admitted directly to the hospital from the emergency room, you do not have to pay the $125 emergency room copayment. However, the $175 per day copayment for Preferred inpatient care still applies. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits. ***Note:*** Regular benefit levels apply to covered services provided in settings other than an emergency room or urgent care center. See Section 5(a), Medical services and supplies, Section 5(b), Surgical procedures, and Section 5(c), Outpatient hospital, for the benefits we provide.
Not covered: • *Oral surgery except as shown in Section 5(b)* • *Injury to the teeth while eating* • *Emergency room professional charges for shift differentials*	*All charges*	*All charges*

Medical emergency	You Pay	
	Standard Option	Basic Option
• **Physician services** including diagnostic studies, radiology services, laboratory tests, and pathology services • Related outpatient **hospital services** and supplies, including diagnostic studies, radiology services, laboratory tests, and pathology services ***Note:*** We pay Inpatient professional and hospital benefits if you are admitted as a result of a medical emergency [see Sections 5(a), 5(b), and 5(c)]. ***Note:*** Please refer to Section 3 for information about precertifying emergency hospital admissions. ***Note:*** Regular benefit levels apply to covered services provided in settings other than an emergency room or urgent care center. See Section 5(a), Medical services and supplies, Section 5(b), Surgical procedures, and Section 5(c), Outpatient hospital, for the benefits we provide.	Preferred urgent care center: $40 copayment per visit (no deductible) Participating urgent care center: 35% of the Plan allowance (deductible applies) Non-participating urgent care center: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount Preferred emergency room: 15% of the Plan allowance (deductible applies) Participating/Member emergency room: 15% of the Plan allowance (deductible applies) Non-participating/Non-member emergency room: 15% of the Plan allowance (deductible applies). If you use a Non-participating provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** These benefit levels **do not** apply if you receive care in connection with, and within 72 hours after, an accidental injury. See Accidental Injury benefits on page 91 for the benefits we provide.	Preferred urgent care center: $50 copayment per visit Participating/Non-participating urgent care center: You pay all charges Preferred emergency room: $125 copayment per visit Participating/Member emergency room: $125 copayment per visit Non-participating/Non-member emergency room: $125 copayment per visit, plus any difference between our allowance and the billed amount ***Note:*** If you are admitted directly to the hospital from the emergency room, you do not have to pay the $125 emergency room copayment. However, the $175 per day copayment for Preferred inpatient care still applies. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.
Not covered: Emergency room professional charges for shift differentials	*All charges*	*All charges*

Ambulance	You Pay	
	Standard Option	Basic Option
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and: • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required. ***Note:*** See Section 5(c) for non-emergency ambulance services.	Preferred: $100 copayment per day for ground ambulance transport services (no deductible) Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services (no deductible) ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day (no deductible).	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.
Local professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required.	Preferred: Nothing (no deductible) Participating/Member or Non-participating/Non-member: Nothing (no deductible) ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.	Preferred: $100 copayment per day for ground ambulance transport services Participating/Member or Non-participating/Non-member: $100 copayment per day for ground ambulance transport services ***Note:*** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.
Not covered: • *Wheelchair van services and gurney van services* • *Ambulance and any other modes of transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests not associated with covered inpatient hospital care*	*All charges*	*All charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you have a chronic and/or complex condition, you may be eligible to receive the services of a professional case manager to assist in assessing, planning, and facilitating individualized treatment options and care. For more information about our Case Management process, please refer to pages 120 and 141. Contact us at the telephone number listed on the back of your Service Benefit Plan ID card if you have any questions or would like to discuss your health care needs.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
  - The calendar year deductible is $350 per person ($700 per family).
  - You may choose to receive care from In-Network (Preferred) or Out-of-Network (Non-preferred) providers. Cost-sharing and limitations for In-Network (Preferred) and Out-of-Network (Non-preferred) mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.
- **Under Basic Option,**
  - **You must use Preferred providers in order to receive benefits. See page 21 for the exceptions to this requirement.**
  - There is **no calendar year deductible**.

Benefit Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Professional services	**Standard Option**	**Basic Option**
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.

Professional services – continued on next page

Professional services *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Services provided by licensed professional mental health and substance abuse practitioners when acting within the scope of their license • Individual psychotherapy • Group psychotherapy • Pharmacologic (medication) management • Psychological testing • Office visits • Clinic visits • Home visits ***Note:*** To locate a Preferred provider, go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder, or contact your Local Plan at the mental health and substance abuse phone number on the back of your ID card. ***Note:*** See pages 61 and 102 for our coverage of smoking and tobacco cessation treatment. ***Note:*** See page 46 for our coverage of mental health visits to treat postpartum depression and depression during pregnancy.	Preferred: $20 copayment for the visit (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus the difference between our allowance and the billed amount	Preferred: $25 copayment per visit Participating/Non-participating: You pay all charges
• Inpatient professional visits	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus the difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
• Professional charges for facility-based intensive outpatient treatment • Professional charges for outpatient diagnostic tests	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus the difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

Inpatient hospital or other covered facility	You Pay	
	Standard Option	Basic 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 • Diagnostic tests ***Note:*** Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a hospital/treatment facility (excluding a residential treatment center) for rehabilitative treatment of alcoholism or substance abuse. ***Note:*** A residential treatment center is not a covered hospital/treatment facility. See Section 10, *Definitions*, for more information. ***Note:*** You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	Preferred: $250 per admission copayment for unlimited days (no deductible) Member: $350 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member: $350 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member: You pay all charges
Outpatient hospital or other covered facility		
Outpatient services provided and billed by a hospital or other covered facility • Individual psychotherapy • Group psychotherapy • Pharmacologic (medication) management • Partial hospitalization • Intensive outpatient treatment ***Note:*** A residential treatment center is not a covered hospital/treatment facility. See Section 10, *Definitions*, for more information.	Preferred: 15% of the Plan allowance (deductible applies) Member: 35% of the Plan allowance (deductible applies) Non-member: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred: $25 copayment per day per facility Member/Non-member: You pay all charges
Outpatient services provided and billed by a hospital or other covered facility • Diagnostic tests • Psychological testing ***Note:*** A residential treatment center is not a covered hospital/treatment facility. See Section 10, *Definitions*, for more information.	Preferred: 15% of the Plan allowance (deductible applies) Member: 35% of the Plan allowance (deductible applies) Non-member: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred: Nothing Member/Non-member: Nothing

Not covered (Inpatient or Outpatient)	You Pay	
	Standard Option	Basic Option
• *Marital, family, educational, or other counseling or training services* • *Services performed by a noncovered provider* • *Testing and treatment for learning disabilities and mental retardation* • *Applied behavior analysis (ABA) or ABA therapy* • *Services performed or billed by residential treatment centers, schools, halfway houses, or members of their staffs* ***Note:*** *We cover professional services as described on pages 94 and 95 when they are provided and billed by a covered professional provider acting within the scope of his or her license.* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present* • *Services performed or billed by residential therapeutic camps (e.g., wilderness camps, Outward Bound, etc.)* • *Light boxes* • *Custodial or long term care (see* Definitions*)*	*All charges*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescription drugs and supplies, as described in the chart beginning on page 101.
- 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 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRIOR APPROVAL FOR CERTAIN DRUGS AND SUPPLIES, and prior approval must be renewed periodically.** Prior approval is part of our Patient Safety and Quality Monitoring (PSQM) program. Please refer to page 100 for more information about the PSQM program and to Section 3 for more information about prior approval.
- During the course of the year, we may move a brand-name drug from Tier 2 (preferred brand-name) to Tier 3 (non-preferred brand-name) if a generic equivalent becomes available or if new safety concerns arise. We may also move a specialty drug from Tier 4 (preferred) to Tier 5 (non-preferred) if a generic equivalent becomes available or if new safety concerns arise. If your drug is moved to a higher Tier, your cost-share will increase. Tier reassignments during the year are not considered benefit changes.
- **Under Standard Option,**
  - You may use the Retail Pharmacy Program, the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program to fill your prescriptions.
  - The calendar year deductible does **not** apply to prescriptions filled through the Retail Pharmacy Program, the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program.
  - PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Basic Option,**
  - **You must use Preferred providers or the Specialty Drug Pharmacy Program in order to receive benefits. See page 21 for the exceptions to this requirement.** Our specialty drug pharmacy is a Preferred provider.
  - There is **no calendar year deductible**.
  - The Mail Service Prescription Drug Program **is not** available.

We will send each new enrollee a combined prescription drug/Plan identification card. Standard Option members are eligible to use the Mail Service Prescription Drug Program and will also receive a mail service order form and a preaddressed reply envelope.

- **Who can write your prescriptions.** A physician or dentist licensed in the United States, Puerto Rico, or the U.S. Virgin Islands, or a nurse practitioner in states that permit it, must write your prescriptions [see Section 5(i) for drugs purchased overseas].
- **Where you can obtain them.**

  Under Standard Option, you may fill prescriptions at a Preferred retail pharmacy, at a Non-preferred retail pharmacy, through our Mail Service Prescription Drug Program, or through the Specialty Drug Pharmacy Program. Under Standard Option, we pay a higher level of benefits when you use a Preferred retail pharmacy, our Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program. See page 148 for the definition of "specialty drugs."

  Under Basic Option, you must fill prescriptions only at a Preferred retail pharmacy or through the Specialty Drug Pharmacy Program, in order to receive benefits. See page 148 for the definition of "specialty drugs."

  Note: Both Preferred and Non-preferred retail pharmacies may offer options for ordering prescription drugs online. Drugs ordered online may be delivered to your home; however, these online orders are not a part of the Mail Service Prescription Drug Program, described on page 107.

  Note: Due to manufacturer restrictions, a small number of specialty drugs used to treat rare or uncommon conditions may be available only through a Preferred retail pharmacy. See page 105 for information about your cost-share for specialty drugs purchased at a Preferred retail pharmacy that are affected by these restrictions.

- **We use an open formulary.** This includes a list of preferred drugs selected to meet patient needs at a lower cost to us. If your physician believes a brand-name drug is necessary or there is no generic equivalent available, ask your physician to prescribe a brand-name drug from our preferred drug list.

  Under Standard Option, we may ask your doctor to substitute a preferred drug in order to help control costs. If you purchase a drug that is not on our preferred drug list, your cost will be higher. We cover drugs that require a prescription (whether or not they are on our preferred drug list). Your cooperation with our cost-savings efforts helps keep your premium affordable.

  Under Basic Option, we encourage you to ask your physician to prescribe a brand-name drug from our preferred drug list when your physician believes a brand-name drug is necessary or when there is no generic equivalent available. If you purchase a drug that is not on our preferred drug list, your cost will be higher. (We cover drugs that require a prescription whether or not they are on our preferred drug list.)

  ***Note:* Before filling your prescription, please check the preferred/non-preferred status of your medication.** Other than changes resulting from new drugs or safety issues, the preferred drug list is updated periodically during the year.

  Member cost-share for prescription drugs is determined by the tier to which a drug has been assigned. To determine the tier assignments for formulary drugs, we work with our Pharmacy and Therapeutics Committee, a group of physicians and pharmacists who are not employees or agents of, nor have financial interest in, the Blue Cross and Blue Shield Service Benefit Plan. The Committee meets quarterly to review new and existing drugs to assist us in our assessment of these drugs for safety and efficacy. Drugs determined to be of equal therapeutic value and similar safety and efficacy are then evaluated on the basis of cost. The Committee's recommendations, together with our evaluation of the relative cost of the drugs, determine the placement of formulary drugs on a specific tier. Using lower cost preferred drugs will provide you with a high quality, cost-effective prescription drug benefit.

  Our payment levels are generally categorized as:

  Tier 1: Includes generic drugs
  Tier 2: Includes preferred brand-name drugs
  Tier 3: Includes non-preferred brand-name drugs
  Tier 4: Includes preferred specialty drugs
  Tier 5: Includes non-preferred specialty drugs

  You can view our formulary which includes the preferred drug list on our Web site at www.fepblue.org or request a copy by mail by calling 1-800-624-5060 (TDD: 1-800-624-5077). If you do not find your drug on the formulary or the preferred drug list, please call 1-800-624-5060. Any savings we receive on the cost of drugs purchased under this Plan from drug manufacturers are credited to the reserves held for this Plan.

- **Generic equivalents.**

  Generic equivalent drugs have the same active ingredients as their brand-name equivalents. By filling your prescriptions (or those of family members covered by the Plan) at a retail pharmacy, through the Specialty Drug Pharmacy Program, or, for Standard Option only, through the Mail Service Prescription Drug Program, you authorize the pharmacist to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a brand-name drug. Keep in mind that **Basic Option members must use Preferred providers in order to receive benefits.**

- **Why use generic drugs?** Generic drugs are generally lower cost drugs. Generic drugs have the same quality and strength as brand-name drugs and must meet the same strict standards for quality and effectiveness set by the U.S. Food and Drug Administration (FDA), as brand-name drugs.

  You can save money by using generic drugs. Keep in mind that doctors often have several medication options to treat their patients. If your brand-name drug does not have an equivalent generic drug, there may be a generic alternative drug available to treat your condition. You may want to talk with your doctor about generic drugs and how you can reduce your prescription drug costs. You or your doctor may request a brand-name drug even if a generic option is available. See Section 10, *Definitions*, for more information about generic alternatives and generic equivalents.

- **Disclosure of information.** As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including the names of your prescribing physicians, to any treating physicians or dispensing pharmacies.

- **These are the dispensing limitations.**

  Standard Option: Subject to manufacturer packaging and your prescriber's instructions, you may purchase **up to** a 90-day supply of covered drugs and supplies through the Retail or Specialty Drug Pharmacy Program. You may purchase a supply of **more than** 21 days **up to** 90 days through the Mail Service Prescription Drug Program for a single copayment.

  Basic Option: When you fill Tier 1 (generic), Tier 2 (preferred brand-name), and Tier 3 (non-preferred brand-name) prescriptions for the first time, you may purchase **up to** a 30-day supply for a single copayment. For additional copayments, you may purchase **up to** a 90-day supply for continuing prescriptions and for refills. See pages 105 and 108 for dispensing limitations when you fill Tier 4 and Tier 5 specialty drug prescriptions.

  Note: Certain drugs such as narcotics may have additional FDA limits on the quantities that a pharmacy may dispense. In addition, pharmacy dispensing practices are regulated by the state where they are located and may also be determined by individual pharmacies. Due to safety requirements, some medications are dispensed as originally packaged by the manufacturer and we cannot make adjustments to the packaged quantity or otherwise open or split packages to create 90-day supplies of those medications. **In most cases, refills cannot be obtained until 75% of the prescription has been used.** Call us or visit our Web site if you have any questions about dispensing limits. Please note that in the event of a national or other emergency, or if you are a reservist or National Guard member who is called to active military duty, you should contact us regarding your prescription drug needs. See the contact information below.

- **Important contact information.**

  Standard Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077); Mail Service Prescription Drug Program: 1-800-262-7890 (TDD: 1-800-216-5343); Specialty Drug Pharmacy Program: 1-888-346-3731 (TDD: 1-877-853-9549); or www.fepblue.org.

  Basic Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077); Specialty Drug Pharmacy Program: 1-888-346-3731 (TDD: 1-877-853-9549); or www.fepblue.org.

Patient Safety and Quality Monitoring (PSQM)

We have a special program to promote patient safety and monitor health care quality. Our Patient Safety and Quality Monitoring (PSQM) program features a set of closely aligned programs that are designed to promote the safe and appropriate use of medications. Examples of these programs include:

- Prior approval – As described below, this program requires that approval be obtained for certain prescription drugs and supplies before we provide benefits for them.
- Safety checks – Before your prescription is filled, we perform quality and safety checks for usage precautions, drug interactions, drug duplication, excessive use, and frequency of refills.
- Quantity allowances – Specific allowances for several medications are based on FDA-approved recommendations, clinical studies, and manufacturer guidelines.

For more information about our PSQM program, including listings of drugs subject to prior approval or quantity allowances, visit our Web site at www.fepblue.org or call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077).

Prior Approval

As part of our Patient Safety and Quality Monitoring (PSQM) program (see above), **you must make sure that your physician obtains prior approval for certain prescription drugs and supplies in order to use your prescription drug coverage.** In providing prior approval, we may limit benefits to quantities prescribed in accordance with accepted standards of medical, dental, or psychiatric practice in the United States. **Prior approval must be renewed periodically.** To obtain a list of these drugs and supplies and to obtain prior approval request forms, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077). You can also obtain the list through our Web site at www.fepblue.org. Please read Section 3 for more information about prior approval.

Please note that updates to the list of drugs and supplies requiring prior approval are made periodically during the year. New drugs and supplies may be added to the list and prior approval criteria may change. Changes to the prior approval list or to prior approval criteria are not considered benefit changes.

Note: If your prescription requires prior approval and you have not yet obtained prior approval, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.

Covered medications and supplies

Standard Option Generic Incentive Program

Your cost-share will be waived for the first 4 generic prescriptions filled (and/or refills ordered) per drug per calendar year if you purchase a brand-name drug listed below while a member of the Service Benefit Plan and then change to a corresponding generic drug replacement while still a member of the Plan.

Preferred Retail Pharmacy

- Your 20% coinsurance amount (15% when Medicare Part B is primary) is waived for the first 4 generic drug replacements filled (and/or refills ordered) per drug per calendar year. You may receive up to 4 coinsurance waivers per drug change per year.
- If you switch from one generic drug to another, you will be responsible for your coinsurance amount.
- Both the brand-name drug and its corresponding generic drug replacement must be purchased during the same calendar year.

Mail Service Prescription Drug Program

- Your $15 copayment ($10 when Medicare Part B is primary) is waived for the first 4 generic drug replacements filled (and/or refills ordered) per drug per calendar year. You may receive up to 4 copayment waivers per drug change per year.
- If you switch from one generic drug to another, you will be responsible for the copayment.
- Both the brand-name drug and its corresponding generic drug replacement must be purchased during the same calendar year.

If you take one of these brand-name drugs . . .	And change to one of these generic drug replacements . . .	
Actonel, Boniva, Fosamax	alendronate or ibandronate	**You will receive your first 4 prescription fills (or refills) of the corresponding generic drug at no charge.** **(Please see the Standard Option Generic Incentive Program description above for complete information.)**
Aciphex, Dexilant (formerly Kapidex), Nexium, Prevacid, Prilosec, Protonix, Zegerid	omeprazole, lansoprazole, or pantoprazole	
Ambien CR, Lunesta, Rozerem	zaleplon, zolpidem, or zolpidem extended-release	
Advicor, Altoprev, Crestor, Lescol, Lescol XL, Lipitor, Livalo, Mevacor, Pravachol, Simcor, Vytorin, Zocor	simvastatin, pravastatin, lovastatin, atorvastatin, or fluvastatin	
Caduet	simvastatin, pravastatin, lovastatin, atorvastatin, fluvastatin, amlodipine, or amlodipine/atorvastatin	
Famvir	famciclovir	
Valtrex	valacyclovir	
Atacand, Avapro, Benicar, Cozaar, Diovan, Micardis, Teveten	losartan, candesartan, irbesartan, or eprosartan	
Atacand HCT, Avalide, Benicar HCT, Diovan HCT, Hyzaar, Micardis HCT, Teveten HCT	losartan HCTZ, candesartan HCT, irbesartan HCT, or eprosartan HCTZ	
Detrol, Oxytrol, Sanctura, Toviaz, Vesicare	oxybutynin, oxybutynin extended-release, or trospium	
Detrol LA, Enablex, Sanctura XR	oxybutynin extended-release or trospium extended-release	
Betimol, Istalol, Timoptic-XE, Optipranolol	timolol maleate ophthalmic	

Please note the list of eligible generic drug replacements may change if additional generic drugs corresponding to the listed brand-name drugs become available during the year. For the most up-to-date information, please visit our Pharmacy Program Web site through www.fepblue.org.

Covered medications and supplies – continued on next page

Benefit Description	You Pay	
Note: For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.		
Covered medications and supplies *(continued)*	**Standard Option**	**Basic Option**
• Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase ***Note:*** See page 104 for our coverage of medicines to promote better health as recommended under the Affordable Care Act. ***Note:*** See Section 5(a), page 58, for our coverage of medical foods for children and for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube. • Insulin ***Note:*** See page 57 for our coverage of insulin pumps. • Diabetic test strips • Lancets • Needles and disposable syringes for the administration of covered medications • Clotting factors and anti-inhibitor complexes for the treatment of hemophilia • Drugs to aid smoking and tobacco cessation that require a prescription by Federal law ***Note:*** We provide benefits for over-the-counter (OTC) smoking and tobacco cessation medications only as described on page 109. ***Note:*** You may be eligible to receive smoking and tobacco cessation medications at no charge. See page 109 for more information. • Contraceptive drugs and devices, limited to: – Diaphragms and contraceptive rings – Injectable contraceptives – Intrauterine devices (IUDs) – Implantable contraceptives – Oral and transdermal contraceptives ***Note:*** We waive your cost-share for generic contraceptives and for brand-name contraceptives that have no generic equivalent or generic alternative, when you purchase them at a Preferred retail pharmacy or, for Standard Option only, through the Mail Service Prescription Drug Program. See pages 105 and 107 for details. • Drugs for the diagnosis and treatment of infertility, except as described on page 111	See page 101 and pages 103-110	See page 101 and pages 103-110

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
• Over-the-counter (OTC) contraceptive drugs and devices, for women only, limited to: – Emergency contraceptive pills – Female condoms – Spermicides – Sponges ***Note:*** We provide benefits in full for OTC contraceptive drugs and devices for women only when the contraceptives meet FDA standards for OTC products. To receive benefits, you must use a Preferred retail pharmacy and present the pharmacist with a written prescription from your physician.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges	Preferred retail pharmacy: Nothing Non-preferred retail pharmacy: You pay all charges
Routine immunizations when provided by a Preferred retail pharmacy that participates in our vaccine network (see below) and administered in compliance with applicable state law and pharmacy certification requirements, limited to: • Herpes Zoster (shingles) vaccines • Human Papillomavirus (HPV) vaccines • Influenza (flu) vaccines • Pneumococcal vaccines • Meningococcal vaccines ***Note:*** Our vaccine network is a network of Preferred retail pharmacies that have agreements with us to administer one or more of the routine immunizations listed above. Check with your pharmacy or call our Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) to see which vaccines your pharmacy can provide.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges (except as noted below) ***Note:*** You pay nothing for Influenza (flu) vaccines obtained at Non-preferred retail pharmacies.	Preferred retail pharmacy: Nothing Non-preferred retail pharmacy: You pay all charges (except as noted below) ***Note:*** You pay nothing for Influenza (flu) vaccines obtained at Non-preferred retail pharmacies.

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Medicines to promote better health as recommended under the Patient Protection and Affordable Care Act (the "Affordable Care Act"), limited to: • Iron supplements for children from age 6 months through 12 months • Oral fluoride supplements for children from age 6 months through 5 years • Folic acid supplements, 0.4 mg to 0.8 mg, for women capable of pregnancy • Vitamin D supplements for adults, age 65 and over, limited to a recommended daily allowance of 600-800 international units (I.U.s) per day • Aspirin for men age 45 through 79 and women age 55 through 79 ***Note:*** Benefits are not available for *Tylenol, Ibuprofen, Aleve*, etc. ***Note:*** Benefits for the medicines listed above are subject to the dispensing limitations described on page 100 and are limited to recommended prescribed limits. ***Note:*** To receive benefits, you must use a Preferred retail pharmacy and present a written prescription from your physician to the pharmacist. ***Note:*** For a complete list of preventive services recommended under the Affordable Care Act, visit: http://www.healthcare.gov/prevention/index.html. See pages 41-45 in Section 5(a) for information about other covered preventive care services. ***Note:*** See page 109 for our coverage of smoking and tobacco cessation medicines.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges	Preferred retail pharmacy: Nothing Non-preferred retail pharmacy: You pay all charges

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	You Pay	
	Standard Option	**Basic Option**
Here is how to obtain your prescription drugs and supplies: **Preferred Retail Pharmacies** • Make sure you have your Plan ID card when you are ready to purchase your prescription • Go to any Preferred retail pharmacy, or • Visit the Web site of your Preferred retail pharmacy to request your prescriptions • For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site, www.fepblue.org ***Note:*** Retail pharmacies that are Preferred for prescription drugs are not necessarily Preferred for durable medical equipment (DME) and medical supplies. To receive Preferred benefits for DME and covered medical supplies, you must use a Preferred DME or medical supply provider. See Section 5(a) for the benefit levels that apply to DME and medical supplies. ***Note:*** Benefits for Tier 4 and Tier 5 specialty drugs purchased at a Preferred retail pharmacy are limited to one purchase of up to a 30-day supply for each prescription dispensed. All refills must be obtained through the Specialty Drug Pharmacy Program. See page 108 for more information. ***Note:*** For prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility, we provide benefits as shown on this page for drugs obtained from a retail pharmacy, as long as the pharmacy supplying the prescription drugs to the facility is a Preferred pharmacy. **For benefit information about prescription drugs supplied by Non-preferred retail pharmacies, please refer to page 106.** ***Note:*** For a list of the Preferred Network Long Term Care pharmacies, call 1-800-624-5060 (TDD: 1-800-624-5077). ***Note:*** For coordination of benefits purposes, if you need a statement of Preferred retail pharmacy benefits in order to file claims with your other coverage when this Plan is the primary payor, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site at www.fepblue.org. ***Note:*** We waive your cost-share for available forms of generic contraceptives and for brand-name contraceptives that have no generic equivalent or generic alternative.	Tier 1 (generic drug): 20% of the Plan allowance (no deductible) ***Note:*** You pay 15% of the Plan allowance when Medicare Part B is primary. ***Note:*** You may be eligible to receive your first 4 generic prescriptions filled (and/or refills ordered) at no charge when you change from certain brand-name drugs to a corresponding generic drug replacement. See page 101 for complete information. Tier 2 (preferred brand-name drug): 30% of the Plan allowance (no deductible) Tier 3 (non-preferred brand-name drug): 45% of the Plan allowance (no deductible) Tier 4 (preferred specialty drug): 30% of the Plan allowance (no deductible), limited to one purchase of up to a 30-day supply Tier 5 (non-preferred specialty drug): 30% of the Plan allowance (no deductible), limited to one purchase of up to a 30-day supply ***Note:*** If there is no generic drug available, you must still pay the brand-name coinsurance amount when you receive a brand-name drug. ***Note:*** We may move a Tier 2 brand-name drug to Tier 3 or a Tier 4 specialty drug to Tier 5 during the course of the year. See page 98 for more information.	Tier 1 (generic drug): $10 copayment for each purchase of up to a 30-day supply ($30 copayment for 90-day supply) Tier 2 (preferred brand-name drug): $45 copayment for each purchase of up to a 30-day supply ($135 copayment for 90-day supply) Tier 3 (non-preferred brand-name drug): 50% of Plan allowance ($55 minimum) for each purchase of up to a 30-day supply, ($165 minimum for 90-day supply) Tier 4 (preferred specialty drug): $60 for up to a 30-day supply only Tier 5 (non-preferred specialty drug): $80 for up to a 30-day supply only ***Note:*** If there is no generic drug available, you must still pay the brand-name copayment when you receive a brand-name drug. ***Note:*** We may move a Tier 2 brand-name drug to Tier 3 or a Tier 4 specialty drug to Tier 5 during the course of the year. See page 98 for more information. ***Note:*** For generic and brand-name drug purchases, if the cost of your prescription is less than your cost-sharing amount noted above, you pay only the cost of your prescription.

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Non-preferred Retail Pharmacies	45% of the Plan allowance (Average wholesale price – AWP), plus any difference between our allowance and the billed amount (no deductible) ***Note:*** If you use a Non-preferred retail pharmacy, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.	*All charges*

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	You Pay	
	Standard Option	**Basic Option**
Mail Service Prescription Drug Program Under Standard Option, if your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you can use this service for your prescriptions and refills. Please refer to Section 7 for instructions on how to use the Mail Service Prescription Drug Program. ***Note:*** Not all drugs are available through the Mail Service Prescription Drug Program. There are no specialty drugs available through the Mail Service Program. Please refer to page 108 for information about the Specialty Drug Pharmacy Program. ***Note:*** We waive your cost-share for available forms of generic contraceptives and for brand-name contraceptives that have no generic equivalent or generic alternative. ***Contact Us:*** If you have any questions about this program, or need assistance with your Mail Service drug orders, please call 1-800-262-7890 (TDD: 1-800-216-5343).	Mail Service Program: Tier 1 (generic drug): $15 copayment (no deductible) ***Note:*** You pay a $10 copayment per generic prescription filled (and/or refill ordered) when Medicare Part B is primary. ***Note:*** You may be eligible to receive your first 4 generic prescriptions filled (and/or refills ordered) at no charge when you change from certain brand-name drugs to a corresponding generic drug replacement. See page 101 for complete information. Tier 2 (preferred brand-name drug): $80 copayment (no deductible) Tier 3 (non-preferred brand-name drug): $105 copayment (no deductible) ***Note:*** The copayment amounts listed above for brand-name drugs only apply to your first 30 brand-name prescriptions filled (and/or refills ordered) per calendar year; you pay a $50 copayment per brand-name prescription/refill thereafter. ***Note:*** If there is no generic drug available, you must still pay the brand-name copayment when you receive a brand-name drug. ***Note:*** If the cost of your prescription is less than your copayment, you pay only the cost of your prescription. The Mail Service Prescription Drug Program will charge you the lesser of the prescription cost or the copayment when you place your order. If you have already sent in your copayment, they will credit your account with any difference. ***Note:*** We may move a Tier 2 brand-name drug to Tier 3 during the course of the year. See page 98 for more information.	No benefit ***Note:*** Although you do not have access to the Mail Service Prescription Drug Program, you may request home delivery of prescription drugs you purchase from Preferred retail pharmacies offering options for online ordering. See page 105 of this Section for our payment levels for drugs obtained through Preferred retail pharmacies. ***Note:*** See page 108 for information about the Specialty Drug Pharmacy Program.

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	You Pay	
	Standard Option	Basic Option
Specialty Drug Pharmacy Program We cover specialty drugs that are listed on the Service Benefit Plan Specialty Drug List. (See page 148 for the definition of "specialty drugs.") If your doctor orders more than a 21-day supply of covered specialty drugs, you can use this service. A Specialty Drug pharmacy representative will speak with you to schedule delivery and ask you about any side effects each time you order a new prescription or a refill. ***Note:*** Benefits for the first three fills of each Tier 4 or Tier 5 specialty drug are limited to a 30-day supply. Benefits are available for a 90-day supply after the third fill. The Specialty Drug Pharmacy Program will work with you to arrange a delivery time and location that is most convenient for you. Please refer to Section 7 for instructions on using the program. ***Note:*** If your specialty drug order is for 21 days or less, please call the Specialty Drug Pharmacy Program number listed below for assistance. ***Note:*** The list of covered specialty drugs is subject to change. For the most up-to-date listing, call the number listed below or visit our Web site, www.fepblue.org. ***Note:*** Due to manufacturer restrictions, a small number of specialty drugs may only be available through a Preferred retail pharmacy. You will be responsible for paying only the copayments shown here for specialty drugs affected by these restrictions. ***Contact Us:*** If you have any questions about this program, or need assistance with your specialty drug orders, please call 1-888-346-3731 (TDD: 1-877-853-9549).	Specialty Drug Pharmacy Program: Tier 4 (preferred specialty drug): $35 copayment for up to a 30-day supply ($95 copayment for up to a 90-day supply) (no deductible) Tier 5 (non-preferred specialty drug): $55 copayment for up to a 30-day supply ($155 copayment for up to a 90-day supply) (no deductible) ***Note:*** The copayments listed above for 90-day supplies of specialty drugs apply to the first 30 prescriptions refilled or ordered per calendar year; thereafter, your copayment is $50 for each 90-day supply.	Specialty Drug Pharmacy Program: Tier 4 (preferred specialty drug): $50 copayment for up to a 30-day supply ($140 copayment for 90-day supply) Tier 5 (non-preferred specialty drug): $70 copayment for up to a 30-day supply ($195 copayment for 90-day supply)

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	You Pay	
	Standard Option	Basic Option
Smoking and Tobacco Cessation Medications If you are age 18 or over, you may be eligible to obtain specific prescription generic and brand-name smoking and tobacco cessation medications at no charge. Additionally, you may be eligible to obtain over-the-counter (OTC) smoking and tobacco cessation medications, prescribed by your physician, at no charge. These benefits are only available when you use a Preferred retail pharmacy. To qualify, complete the Blue Health Assessment (BHA) questionnaire indicating you are a tobacco user, and create a Tobacco Cessation Quit Plan using our Online Health Coach. For more information, see pages 118 and 119. The following medications are covered through this program: • Generic medications available by prescription: – Bupropion ER 150 mg tablet – Bupropion SR 150 mg tablet • Brand-name medications available by prescription: – Chantix 0.5 mg tablet – Chantix 1 mg cont monthly pack – Chantix 1 mg tablet – Chantix starting monthly pack – Nicotrol cartridge inhaler – Nicotrol NS Spray 10 mg/ml • Over-the-counter (OTC) medications ***Note:*** To receive benefits for over-the-counter (OTC) smoking and tobacco cessation medications, you must have a physician's prescription for each OTC medication that must be filled by a pharmacist at a Preferred retail pharmacy. ***Note:*** These benefits apply only when all of the criteria listed above are met. Regular prescription drug benefits will apply to purchases of smoking and tobacco cessation medications not meeting these criteria. Benefits are not available for over-the-counter (OTC) smoking and tobacco cessation medications except as described above. ***Note:*** See page 61 for our coverage of smoking and tobacco cessation treatment, counseling, and classes.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges	Preferred retail pharmacy: Nothing Non-preferred retail pharmacy: You pay all charges

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	You Pay	
	Standard Option	Basic Option
Drugs from other sources • Covered prescription drugs and supplies not obtained at a retail pharmacy, through the Specialty Drug Pharmacy Program, or, for Standard Option only, through the Mail Service Prescription Drug Program ***Note:*** We cover drugs and supplies purchased overseas as shown here, as long as they are the equivalent to drugs and supplies that by Federal law of the United States require a prescription. Please refer to pages 121 and 122 in Section 5(i) for more information. ***Note:*** For covered prescription drugs and supplies purchased outside of the United States, Puerto Rico, and the U.S. Virgin Islands, please submit claims on an Overseas Claim Form. See Section 5(i) for information on how to file claims for overseas services. • Please refer to the Sections indicated for additional benefit information when you purchase drugs from a: – Physician's office – Section 5(a) – Hospital (inpatient or outpatient) – Section 5(c) – Hospice agency – Section 5(c) • Please refer to page 105 for prescription drugs obtained from a Preferred retail pharmacy, that are billed for by a skilled nursing facility, nursing home, or extended care facility	Preferred: 15% of the Plan allowance (deductible applies) Participating/Member: 35% of the Plan allowance (deductible applies) Non-participating/Non-member: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Member or Non-participating/Non-member: You pay all charges

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Not covered: • *Medical supplies such as dressings and antiseptics* • *Drugs and supplies for cosmetic purposes* • *Drugs and supplies for weight loss* • *Drugs for orthodontic care, dental implants, and periodontal disease* • *Drugs used in conjunction with assisted reproductive technology (ART) and assisted insemination procedures* • *Insulin and diabetic supplies except when obtained from a retail pharmacy or through the Mail Service Prescription Drug Program (under Standard Option only), or except when Medicare Part B is primary* • *Medications and orally taken nutritional supplements that do not require a prescription under Federal law even if your doctor prescribes them or if a prescription is required under your state law* ***Note:*** *See page 104 for our coverage of medicines recommended under the Affordable Care Act and page 109 for smoking and tobacco cessation medications.* ***Note:*** *See Section 5(a), page 58 for our coverage of medical foods for children and for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.* • *Drugs for which prior approval has been denied or not obtained* • *Infant formula other than described on page 58* • *Drugs and supplies related to sex transformations, sexual dysfunction, or sexual inadequacy* • *Drugs purchased through the mail or internet from pharmacies outside the United States by members located in the United States* • *Over-the-counter (OTC) contraceptive drugs and devices, except as described on page 103* • *Drugs used to terminate pregnancy*	*All charges*	*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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be the primary payor for any covered services and your FEDVIP Plan will be secondary to your FEHB Plan. See Section 9, *Coordinating benefits with Medicare and other coverage*, for additional information.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- ***Note:*** We cover inpatient and outpatient hospital care, as well as anesthesia administered at the facility, to treat children up to age 22 with severe dental caries. We cover these services for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient (even if the dental procedure itself is not covered). See Section 5(c) for inpatient and outpatient hospital benefits.
- **Under Standard Option,**
  - The calendar year deductible of $350 per person ($700 per family) applies only to the accidental injury benefit below.
- **Under Basic Option,**
  - There is **no calendar year deductible**.
  - **You must use Preferred providers in order to receive benefits, except in cases of dental care resulting from an accidental injury as described below.**

Accidental injury benefit	You Pay	
	Standard Option	Basic Option
We provide benefits for services, supplies, or appliances for dental care necessary to promptly repair injury to sound natural teeth required as a result of, and directly related to, an accidental injury. To determine benefit coverage, we may require documentation of the condition of your teeth before the accidental injury, documentation of the injury from your provider(s), and a treatment plan for your dental care. We may request updated treatment plans as your treatment progresses. ***Note:*** An **accidental injury** is an injury caused by an external force or element such as a blow or fall and that requires immediate attention. Injuries to the teeth while eating are not considered accidental injuries. ***Note:*** A **sound natural tooth** is a tooth that is whole or properly restored (restoration with amalgams or resin-based composite fillings only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** Under Standard Option, we first provide benefits as shown in the Schedule of Dental Allowances on the following pages. We then pay benefits as shown here for any balances.	$25 copayment per visit ***Note:*** **We provide benefits for accidental dental injury care in cases of medical emergency when performed by Preferred or Non-preferred providers.** See Section 5(d) for the criteria we use to determine if emergency care is required. You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.

Dental benefits – continued on next page

Dental benefits

What is Covered

Standard Option dental benefits are presented in the chart beginning below and continuing on the following pages.

Basic Option dental benefits appear on page 117.

Note: See Section 5(b) for our benefits for Oral and maxillofacial surgery, and Section 5(c) for our benefits for hospital services (inpatient/outpatient) in connection with dental services, available under both Standard Option and Basic Option.

Preferred Dental Network

All Local Plans contract with Preferred dentists who are available in most areas. Preferred dentists agree to accept a negotiated, discounted amount called the Maximum Allowable Charge (MAC) as payment in full for the following services. They will also file your dental claims for you. Under Standard Option, you are responsible, as an out-of-pocket expense, for the difference between the amount specified in this Schedule of Dental Allowances and the MAC. To find a Preferred dentist near you, go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder, or call us at the customer service number on the back of your ID card. You can also call us to obtain a copy of the applicable MAC listing.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

Standard Option dental benefits

Under Standard Option, we pay billed charges for the following services, up to the amounts shown per service as listed in the Schedule of Dental Allowances below and on the following pages. This is a complete list of dental services covered under this benefit for Standard Option. There are no deductibles, copayments, or coinsurance. When you use Non-preferred dentists, you pay all charges in excess of the listed fee schedule amounts. For Preferred dentists, you pay the difference between the fee schedule amount and the MAC (see above).

Standard Option dental benefits	Standard Option Only		
Covered service	**We pay**		**You pay**
Clinical oral evaluations	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left ***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Periodic oral evaluation *(up to 2 per person per calendar year)*	$12	$8	
Limited oral evaluation	$14	$9	
Comprehensive oral evaluation	$14	$9	
Detailed and extensive oral evaluation	$14	$9	

Dental benefits – continued on next page

Standard Option dental benefits *(continued)*	Standard Option Only		
Covered service	**We pay**		**You pay**
Diagnostic imaging	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left ***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Intraoral complete series	$36	$22	
Intraoral periapical first image	$7	$5	
Intraoral periapical each additional image	$4	$3	
Intraoral occlusal image	$12	$7	
Extraoral first image	$16	$10	
Extraoral each additional image	$6	$4	
Bitewing – single image	$9	$6	
Bitewings – two images	$14	$9	
Bitewings – four images	$19	$12	
Vertical bitewings	$12	$7	
Posterior-anterior or lateral skull and facial bone survey image	$45	$28	
Panoramic image	$36	$23	
Tests and laboratory exams			
Pulp vitality tests	$11	$7	
Palliative treatment			
Palliative (emergency) treatment of dental pain – minor procedure	$24	$15	
Protective restoration	$24	$15	
Preventive			
Prophylaxis – adult *(up to 2 per person per calendar year)*	---	$16	
Prophylaxis – child *(up to 2 per person per calendar year)*	$22	$14	
Topical application of fluoride or fluoride varnish	$13	$8	
Space maintenance (passive appliances)			
Space maintainer – fixed – unilateral	$94	$59	
Space maintainer – fixed – bilateral	$139	$87	
Space maintainer – removable – unilateral	$94	$59	
Space maintainer – removable – bilateral	$139	$87	
Recementation of space maintainer	$22	$14	

Dental benefits – continued on next page

Standard Option dental benefits *(continued)*	Standard Option Only		
Covered service	**We pay**		**You pay**
Amalgam restorations (including polishing)	**To Age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left ***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Amalgam – one surface, primary or permanent	$25	$16	
Amalgam – two surfaces, primary or permanent	$37	$23	
Amalgam – three surfaces, primary or permanent	$50	$31	
Amalgam – four or more surfaces, primary or permanent	$56	$35	
Resin-based composite restorations			
Resin-based composite – one surface, anterior	$25	$16	
Resin-based composite – two surfaces, anterior	$37	$23	
Resin-based composite – three surfaces, anterior	$50	$31	
Resin-based composite – four or more surfaces or involving incisal angle (anterior)	$56	$35	
Resin-based composite – one surface, posterior	$25	$16	
Resin-based composite – two surfaces, posterior	$37	$23	
Resin-based composite – three surfaces, posterior	$50	$31	
Resin-based composite – four or more surfaces, posterior	$50	$31	
Inlay restorations			
Inlay – metallic – one surface	$25	$16	
Inlay – metallic – two surfaces	$37	$23	
Inlay – metallic – three or more surfaces	$50	$31	
Inlay – porcelain/ceramic – one surface	$25	$16	
Inlay – porcelain/ceramic – two surfaces	$37	$23	
Inlay – porcelain/ceramic – three or more surfaces	$50	$31	
Inlay – resin-based composite – one surface	$25	$16	
Inlay – resin-based composite – two surfaces	$37	$23	
Inlay – resin-based composite – three or more surfaces	$50	$31	
Other restorative services			
Pin retention – per tooth, in addition to restoration	$13	$8	

Dental benefits – continued on next page

Standard Option dental benefits *(continued)*	Standard Option Only		
Covered service	**We pay**		**You pay**
Extractions – includes local anesthesia and routine post-operative care	**To Age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left ***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Extraction, erupted tooth or exposed root	$30	$19	
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$43	$27	
Surgical removal of residual tooth roots (cutting procedure)	$71	$45	
General anesthesia in connection with covered extractions	$43	$27	
Not covered: Any service not specifically listed above	*Nothing*	*Nothing*	*All charges*

Dental benefits – continued on next page

Basic Option dental benefits

Under Basic Option, we provide benefits for the services listed below. You pay a $25 copayment for each evaluation, and we pay any balances in full. This is a complete list of dental services covered under this benefit for Basic Option. You **must** use a Preferred dentist in order to receive benefits. For a list of Preferred dentists, go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder, or call us at the customer service number on the back of your ID card.

Basic Option dental benefits	Basic Option Only	
Covered service	**We pay**	**You pay**
Clinical oral evaluations Periodic oral evaluation* Limited oral evaluation Comprehensive oral evaluation* *Benefits are limited to a combined total of 2 evaluations per person per calendar year	Preferred: All charges in excess of your $25 copayment Participating/Non-participating: Nothing	Preferred: $25 copayment per evaluation Participating/Non-participating: You pay all charges
Diagnostic imaging Intraoral – complete series including bitewings *(limited to 1 complete series every 3 years)* Bitewing – single image* Bitewings – two images* Bitewings – four images* *Benefits are limited to a combined total of 4 images per person per calendar year		
Preventive Prophylaxis – adult *(up to 2 per calendar year)* Prophylaxis – child *(up to 2 per calendar year)* Topical application of fluoride or fluoride varnish – for children only *(up to 2 per calendar year)* Sealant – per tooth, first and second molars only *(once per tooth for children up to age 16 only)*		
Not covered: Any service not specifically listed above	*Nothing*	*All charges*

Section 5(h). Special features

Special feature	Description
Health Tools	Stay connected to your health and get the answers you need when you need them by using Health Tools 24 hours a day, 365 days a year. Go to www.fepblue.org or call 1-888-258-3432 toll-free to check out these valuable easy-to-use services: • Talk directly with a **Registered Nurse** any time of the day or night via telephone, secure email, or live chat. Ask questions, get medical advice, or get help determining when to go to see a doctor. Please keep in mind that benefits for any health care services you may seek after using Health Tools are subject to the terms of your coverage under this Plan. • **Personal Health Record** – Access your secure online personal health record for information such as the medications you're taking, recent test results, and medical appointments. Update, store, and track health-related information at any time. • **Blue Health Assessment** – Complete this online health and lifestyle questionnaire and receive additional assistance with your health care expenses. See page 119 for complete information. • **Tobacco Cessation Incentive Program** – If you are age 18 or over and would like to quit smoking, you can participate in this program and receive tobacco cessation products at no charge. Start by completing the Blue Health Assessment (BHA) questionnaire indicating you are a tobacco user, and create a Tobacco Cessation Quit Plan using our Online Health Coach. You will then be eligible to receive certain smoking and tobacco cessation medications at no charge. Both prescription and over-the-counter (OTC) tobacco cessation products obtained from a Preferred retail pharmacy are included in this program. See page 109 for more information. • **My Multimedia Health Library** offers an extensive variety of educational tools using videos, recorded messages, and colorful online material that provide up-to-date information about a wide range of health-related topics. • **Benefits Statements** – Access quarterly and annual statements of recent medical and pharmacy claims and out-of-pocket costs for each family member.
Services for the deaf and hearing impaired	All Blue Cross and Blue Shield Plans provide TDD access for the hearing impaired to access information and receive answers to their questions.
Web accessibility for the visually impaired	Our Web site, www.fepblue.org, adheres to the most current Section 508 Web accessibility standards to ensure that visitors with visual impairments can use the site with ease. Adjust the text size by clicking on the plus ("+") or minus ("–") boxes that appear at the top right of every page.
Travel benefit/services overseas	Please refer to Section 5(i) for benefit and claims information for care you receive outside the United States, Puerto Rico, and the U.S. Virgin Islands.
Healthy Families	Our Healthy Families suite of resources is for families with children and teens, ages 2-19. Healthy Families provides activities and tools to help parents teach their children about weight management, nutrition, physical activity, and personal wellbeing. For more information, go to www.fepblue.org.
***WalkingWorks*® Wellness Program**	*WalkingWorks*® can help you walk your way to better health through online tools and resources that encourage you to incorporate walking into your daily routine and to set – and achieve – personal wellness goals. Receive a pedometer to count your daily steps and then record your progress with the online *WalkingWorks* tracking tool. Log in at www.fepblue.org and start walking your way to better health. If you do not have access to the internet, please call us at 1-888-706-2583. *WalkingWorks* was developed in cooperation with the President's Council on Physical Fitness and Sports.

Special features – continued on next page

Blue Health Assessment	The **Blue Health Assessment (BHA)** questionnaire is an easy and engaging online health evaluation program which can be completed in 10-15 minutes. Your BHA answers are evaluated to create a unique health action plan. Based on the results of your BHA, you can select personalized goals, receive supportive advice, and easily track your progress through our Online Health Coach. When you complete your BHA, you are entitled to receive a $40 health account to be used for most qualified medical expenses. For those with Self and Family coverage, up to two (2) adult members, age 18 or over, are eligible for the $40 health account. We will send each eligible member a debit card to access his or her account. Please keep your card for future use even if you use all of your health account dollars; you may be eligible for wellness incentives in subsequent benefit years. We do not send new cards to continuing participants. If you leave the Service Benefit Plan, any money remaining in your account will be forfeited. In addition to the $40 health account, you are entitled to receive a maximum of $35 in additional credits to your health account for achieving up to three personalized lifestyle management goals. After completing the BHA, you may access the Online Health Coach to set personalized goals designed to improve your health through increased exercise, healthier nutrition habits, managing your weight, reduced stress, and/or better emotional health. We will add $15 to your health account when you achieve your first goal, $10 when you achieve your second goal, and another $10 when you achieve your third goal. By completing the BHA and a maximum of three lifestyle management goals, you can earn up to a total of $75 in health account dollars. You must complete the BHA and your selected goals during the calendar year in order to receive these incentives. The Online Health Coach also features goals that focus on management of specific medical conditions and we encourage members to take full advantage of these valuable resources. However, **health account dollars are available only when you complete goals related to exercise, nutrition, weight management, stress, and emotional health, and are limited to a maximum of three completed goals per calendar year**. ***Note:*** In order to receive your incentives, **you must complete all eligible activities no later than December 21, 2014,** to allow for end-of-year processing. Please allow ample time to complete all activities by this date. Visit our Web site, www.fepblue.org, for more information and to complete the BHA so you can receive your individualized results and begin working toward achieving your goals. **You may also request a printed BHA** by calling 1-888-258-3432 toll-free.
Diabetes Management Incentive Program	The **Diabetes Management Incentive Program** is designed to provide critical health education to people with diabetes, to help assist people with diabetes in improving their blood sugar control, and help manage or slow the progression of complications related to diabetes. Through this program you can earn a maximum of $75 toward a health account to be used for most qualified medical expenses. To qualify for the Diabetes Management Incentive Program, you must be age 18 or over and complete the Blue Health Assessment (BHA) questionnaire indicating you have diabetes. The BHA is available on our Web site, www.fepblue.org. For those with Self and Family coverage, this incentive program is limited to two (2) adult members. The following activities are rewarded through this program: • $10 for having your A1c test performed by a covered provider (maximum of 2 per year) • $5 for reporting A1c levels to the Diabetes Management Incentive Program via our Web site, www.fepblue.org (maximum of 2 per year) • $10 for receiving diabetic glucose test strips through our pharmacy program (maximum of 4 per year) • $10 for receiving a diabetic foot exam from a covered provider (maximum of 1 per year) You can also receive a maximum of 1 of the following 3 rewards: • $20 for enrolling in a diabetes disease management program (maximum of 1 per year) • $20 for receiving a diabetic education visit from a covered provider (maximum of 1 per year) • $5 for completing a web-based diabetes education quiz on our Web site, www.fepblue.org (maximum of 4 per year) ***Note:*** Once you earn the maximum of $75 through this program for the calendar year, additional eligible activities are encouraged but will not be rewarded. ***Note:*** For more information about this program, including eligibility and enrollment information, please visit www.fepblue.org or call the number on the back of your Service Benefit Plan ID card.

Special features – continued on next page

MyBlue® Customer eService	Visit **MyBlue® Customer eService** at www.fepblue.org to check the status of your claims, change your address of record, request claim forms, request a duplicate or replacement Service Benefit Plan ID card, and track how you use your benefits. Additional features include: • **Online EOBs** – You can view, download, and print your explanation of benefits (EOB) forms. Simply log onto MyBlue® Customer eService via www.fepblue.org and click on the "Medical & Pharmacy Claims" link. From there you can enter the desired date range and select the "EOB" link next to each claim to access your EOB. • **Opt Out of Paper EOBs** – The Service Benefit Plan offers an environmentally friendly way of accessing your EOBs. You can opt out of receiving paper EOBs and access your EOBs exclusively online. From the main menu, select the "EOB Mailing Preference" link and follow the on-screen instructions. • **Personalized Messages** – Our EOBs provide a wide range of messages just for you and your family, ranging from preventive care opportunities to enhancements to our online services!
National Doctor & Hospital Finder℠	To find nationwide listings of Preferred providers, go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder.
Care Management Programs	If you have a chronic disease or complex health care needs, the Service Benefit Plan offers members two types of Care Management Programs that provide patient education and clinical support. • **Case Management:** We provide members with complex health care needs with the services of a professional case manager to assess the needs of the member and when appropriate, coordinate, evaluate, and monitor the member's care. • **Disease Management:** We provide programs to help members adopt effective self-care habits to improve their self-management of diabetes; asthma; chronic obstructive pulmonary disease (COPD); coronary artery disease; congestive heart failure; and certain rare conditions. You may receive information from us regarding the programs available to you in your area. If you have any questions regarding these programs, please contact us at the customer service number on the back of your ID card.
Flexible benefits option	Under the Blue Cross and Blue Shield Service Benefit Plan, our Case Management process may include a **flexible benefits option**. This option allows professional case managers at Local Plans to assist members with certain complex and/or chronic health issues by coordinating complicated treatment plans and other types of complex patient care plans. Through the flexible benefits option, case managers may identify a less costly alternative treatment plan for the member. Members who are eligible to receive services through the flexible benefits option are asked to provide verbal consent for the alternative plan. If you and your provider agree with the plan, alternative benefits will begin immediately and you will be asked to sign an **alternative benefits agreement** that includes the terms listed below, in addition to any other terms specified in the agreement. • Alternative benefits will be made available for a limited period of time and are subject to our ongoing review. You must cooperate with the review process. • If we approve alternative benefits, we do not guarantee that they will be extended beyond the limited time period and/or scope of treatment initially approved or that they will be approved in the future. • The decision to offer alternative benefits is solely ours, and unless otherwise specified in the **alternative benefits agreement**, we may withdraw those benefits at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. If you sign the **alternative benefits agreement**, we will provide the agreed-upon benefits for the stated time period, unless we are misled by the information given to us or circumstances change. You may request an extension of the time period initially approved for alternative benefits, but benefits as stated in this brochure will apply if we do not approve your request. Please note that the written **alternative benefits agreement** must be signed by the member or his/her authorized representative and returned to the Plan case manager within 30 days of the date of the alternative benefits agreement. If the Plan does not receive the signed agreement within 30 days, alternative benefits will be withdrawn and benefits as stated in this brochure will apply. ***Note:*** If we deny a request for precertification or prior approval of regular contract benefits, or if we deny regular contract benefits for services you have already received, you may dispute our denial of regular contract benefits under the OPM disputed claims process (see Section 8).

Section 5(i). Services, drugs, and supplies provided overseas

If you travel or live outside the United States, Puerto Rico, and the U.S. Virgin Islands, you are still entitled to the benefits described in this brochure. Unless otherwise noted in this Section, the same definitions, limitations, and exclusions also apply. See below and page 122 for the claims information we need to process overseas claims. We may request that you provide complete medical records from your provider to support your claim.

Please note that the requirements to obtain precertification for inpatient care and prior approval for those services listed in Section 3 do not apply when you receive care outside the United States.

Overseas claims payment

For **professional care** you receive overseas, we provide benefits at Preferred benefit levels using either our Overseas Fee Schedule or a provider-negotiated discount as our Plan allowance. **The requirement to use Preferred providers in order to receive benefits under Basic Option does not apply when you receive care outside the United States, Puerto Rico, and the U.S. Virgin Islands.**

Under both Standard and Basic Options, when the Plan allowance is based on the Overseas Fee Schedule, you pay any difference between our payment and the amount billed, in addition to any applicable coinsurance and/or copayment amounts. You must also pay any charges for noncovered services (and, under Standard Option only, any applicable deductible amount). **Under both Standard and Basic Options,** when the Plan allowance is a provider-negotiated discount, you are only responsible for your coinsurance and/or copayment amounts and, under Standard Option only, any applicable deductible amount. You must also pay any charges for noncovered services.

For **facility care** you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options** after you pay the applicable copayment or coinsurance. Standard Option members are also responsible for any amounts applied to the calendar year deductible for certain outpatient facility services – please see pages 81-84.

For **prescription drugs purchased at overseas pharmacies**, we provide benefits at Preferred benefit levels, using the billed charge as our Plan allowance. Under both Standard and Basic Options, members pay the applicable coinsurance. Standard Option members are not required to meet the calendar year deductible when they purchase drugs at pharmacies located overseas. See page 110 in Section 5(f) for more information.

For **dental care** you receive overseas, we provide benefits as described in Section 5(g). **Under Standard Option,** you must pay any difference between the Schedule of Dental Allowances and the dentist's charge, in addition to any charges for noncovered services. **Under Basic Option,** you must pay the $25 copayment plus any difference between our payment and the dentist's charge, as well as any charges for noncovered services.

Worldwide Assistance Center

We have a network of participating hospitals overseas that will file your claims for inpatient facility care for you – without an advance payment for the covered services you receive. We also have a network of professional providers who have agreed to accept a negotiated amount as payment in full for their services. The Worldwide Assistance Center can help you locate a hospital or physician in our network near where you are staying. You may also view a list of our network providers on our Web site, www.fepblue.org. You will have to file a claim to us for reimbursement for professional services unless you or your provider contacts the Worldwide Assistance Center in advance to arrange direct billing and payment to the provider.

If you are overseas and need assistance locating providers (whether in or out of our network), contact the Worldwide Assistance Center (provided by AXA Assistance), by calling the center collect at 1-804-673-1678. Members in the United States, Puerto Rico, or the U.S. Virgin Islands should call 1-800-699-4337 or email the Worldwide Assistance Center at fepoverseas@axa-assistance.us. AXA Assistance also offers emergency evacuation services to the nearest facility equipped to adequately treat your condition, translation services, and conversion of foreign medical bills to U.S. currency. You may contact one of their multilingual operators 24 hours a day, 365 days a year.

Filing overseas claims

- **Hospital and physician care**

Most overseas providers are under no obligation to file claims on behalf of our members. **You may need to pay for the services at the time you receive them and then submit a claim to us for reimbursement.** To file a claim for covered hospital and physician services received outside the United States, Puerto Rico, and the U.S. Virgin Islands, send a completed Overseas Claim Form and itemized bills to: Federal Employee Program, Overseas Claims, P.O. Box 261570, Miami, FL 33126. You may also fax your claims to us at 001-410-781-7637 (or 1-888-650-6525 toll-free). We will provide translation and currency conversion services for your overseas claims. Send any written inquiries concerning the processing of your overseas claims to: Mailroom Administrator, FEP® Overseas Claims, P.O. Box 14112, Lexington, KY 40512-4112. You may also email inquiries to us through our Web site (www.fepblue.org) via MyBlue® Customer eService, or call us at 1-888-999-9862, using the appropriate AT&T country codes available at www.fepblue.org under Contact Us. You may obtain Overseas Claim Forms from our Web site, or request them through fepoverseas@axa-assistance.us or your Local Plan.

- **Pharmacy benefits**

Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription. To file a claim for covered drugs and supplies you purchase from pharmacies outside the United States, Puerto Rico, and the U.S. Virgin Islands, send a completed FEP® Retail Prescription Drug Overseas Claim Form, along with itemized pharmacy receipts or bills, to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057, or fax your claim to: 001-480-614-7674. We will provide translation and currency conversion services for your overseas claims. You may obtain claim forms for your drug purchases by writing to this address, by visiting our Web site, www.fepblue.org, or by calling 1-888-999-9862, using the appropriate AT&T country codes available on our Web site under Contact Us. Send any written inquiries concerning drugs you purchase to this address as well.

While overseas, you may be able to order your prescription drugs through the Mail Service Prescription Drug Program (under Standard Option only) or our Specialty Drug Pharmacy Program as long as:

- Your address includes a U.S. zip code (such as with APO and FPO addresses and in U.S. territories),
- The prescribing physician is licensed in the United States, Puerto Rico, or the U.S. Virgin Islands, and
- Delivery of the prescription is permitted by law and is in accordance with the manufacturer's guidelines.

See Section 5(f) for more information about Preferred retail pharmacies with online ordering options, the Mail Service Prescription Drug Program, and the Specialty Drug Pharmacy Program.

The Mail Service Prescription Drug Program is not available under **Basic Option**.

Note: In most cases, temperature-sensitive drugs cannot be sent to APO/FPO addresses due to the special handling they require.

Note: For overseas countries with laws restricting the importation of prescription drugs from any other country, we are unable to ship drugs from our Mail Service Prescription Drug Program to Standard Option members living overseas, or from our Specialty Drug Pharmacy Program to Standard or Basic Option members living overseas, even when a valid APO or FPO address is available. You may continue to obtain your prescription drugs from a local overseas pharmacy and submit a claim to us for reimbursement by faxing it to 001-480-614-7674 or filing it via our Web site at www.fepblue.org/myblue.

Non-FEHB benefits available to Plan members

The benefits on these pages are not part of the FEHB contract or premium, **and you cannot file an FEHB dispute regarding these benefits**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. In addition, these services are not eligible for benefits under the FEHB program. Please do not file a claim for these services. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information, contact us at the phone number on the back of your ID card or visit our Web site at www.fepblue.org.

Blue365®

Blue365® is a discount program available to all Service Benefit Plan members that provides valuable resources for healthier living such as:

- Discounts on laser vision correction
- Discounts on hearing aids
- Discounts on diet and weight management programs

With Blue365, there is no paperwork to fill out. All you have to do is visit the designated Web sites to save. Please visit www.fepblue.org and click on "Blue365." Select *Get Started Now!* and then login to MyBlue® with your Username and Password to learn more about the various Blue365 vendors and discounts.

The Blue Cross and Blue Shield Service Benefit Plan may receive payments from Blue365 vendors. The Plan does not recommend, endorse, warrant, or guarantee any specific Blue365 vendor or item. Vendors and the program are subject to change at any time.

Health Club Memberships

You have access to a network of over 8,000 fitness facilities nationwide through Healthways Fitness Your Way. You pay a $25 initiation fee and a $25 monthly fee per person, by credit card, directly to Healthways. As a member, you're entitled to unlimited visits to network facilities and all amenities included in a general membership.* You are not limited to a specific facility; you can choose to use any facility that participates in the network. There is a three-month commitment. If you stop participating for three months or more, you will need to pay an additional $25 initiation fee. You also have access to online tools, trackers, and the Daily Challenge. For more information or to enroll, go to www.fepblue.org.

*Taxes may apply. Individuals must be 18 or older to purchase a membership.

Discount Drug Program

The Discount Drug Program is available to Service Benefit Plan enrollees at no additional premium cost. It enables you to purchase, at discounted prices, certain prescription drugs that are not covered by the regular prescription drug benefit. Discounts vary by drug product, but average about 20%. The program permits you to obtain discounts on the following drugs:

For sexual/erectile dysfunction: Caverject injection, Cialis tablet, Edex injection, Levitra tablet, Muse suppository, Staxyn tablet, Viagra tablet, and Yohimbine;
For weight loss: Adipex-P, Belviq, Benzphetamine, Bontril PDM, Didrex, Diethylpropion, Meridia capsule, Phendimetrazine, Phentermine, Pro-Fast SR, Qsymia, Suprenza ODT, and Xenical capsule;
For hair removal: Vaniqa cream; *For hair growth:* Propecia;
For skin pigmenting/depigmenting/re-pigmenting: Retinoids [Renova 0.02% (tretinoin) and Avage 0.1% (tazarotene)], Hydroquinone-containing products (Aclaro, Eldoquin Forte, Epiquin Micro, Lustra, Melanex, Melpaque, Nuquin, Obagi Products, Remergent, Solaquin Forte, and Tri-Luma), Monobenzone products (Benoquin), and Tretinoin 0.02%; and
For Miscellaneous: Peridex and Latisse.

Drugs may be added to this list as they are approved by the U.S. Food and Drug Administration (FDA). To use the program, simply present a valid prescription and your Service Benefit Plan ID card at a network retail pharmacy. The pharmacist will ask you for payment in full at the negotiated discount rate. If you have any questions, please call 1-800-624-5060.

Vision Care Affinity Program

Service Benefit Plan members can receive routine eye exams, frames, lenses, conventional contact lenses, and laser vision correction at substantial savings when using Davis Vision network providers. Members have access to over 41,000 service locations including optometrists, ophthalmologists, and many retailers. For a complete description of the program or to find a provider near you, go to www.fepblue.org and click on "Benefit Plans." You may also call us at 1-800-551-3337 between 8:00 a.m. and 11:00 p.m. Eastern Time, Monday to Friday; 9:00 a.m. to 4:00 p.m. on Saturday; or noon to 4:00 p.m. on Sunday. Please be sure to verify that the provider participates in our Vision Care Affinity Program and ask about the discounts available before your visit, as discounts may vary.

Members can save on replacement contact lenses by visiting www.lens123.com or calling 1-800-536-7123. Members can also save up to 25% off the provider's usual fee, or 5% off sales pricing, on laser vision correction procedures. Call 1-800-551-3337 for the nearest location and authorization for the discount.

QualSight® LASIK

QualSight® LASIK offers a nationwide network of credentialed ophthalmologists at over 700 locations in order to provide easy and convenient access for members. Your savings represent 40% to 50% off the overall national average price of traditional LASIK. Significant savings are also provided on newer technologies such as Custom LASIK and bladeless IntraLase.
Call 1-877-358-9327 for your free consultation and to see if you are a candidate for one of these procedures.

QualSight LASIK Pricing per Procedure (per eye)*

Traditional LASIK[1, 2]	$ 895
Traditional LASIK[1, 2] and Lifetime Assurance Plan	$1,295
Traditional LASIK with IntraLase[2]	$1,345
Traditional LASIK with IntraLase[2] and Lifetime Assurance Plan	$1,695
Custom Refractive LASIK[1, 2]	$1,320
Custom LASIK[1, 2] with Lifetime Assurance Plan	$1,595
Custom LASIK with IntraLase[2]	$1,770
Custom LASIK with IntraLase[2] and Lifetime Assurance Plan	$1,995

[1]Pricing includes all FDA-approved procedures (with no additional charges for astigmatism or higher amounts of correction) and surface ablation procedures (PRK, LASEK, Epi-LASIK) as necessary, and as offered at individual network practices. Pricing does not include any required prescription or over-the-counter drugs.

[2]When offered by participating network providers. *A small percentage of providers may charge more for certain procedures, resulting in a higher fee for the procedure. You will be notified of any additional amount prior to scheduling your pre-operative examination with these providers.*

*Provider participation may vary.

ARAG® Legal Center

Members have access to **The Education Center**™ which offers a collection of legal tools and resources that provide helpful tips and simple explanations for complex legal terms and scenarios, as well as guidance on where to turn for more information and assistance. The center includes a secure Personal Information Organizer, Guidebooks and videos, the Law Guide, and an e-newsletter. To access this free service, visit www.fepblue.org, Benefits + Services, select the ARAG Legal Center link, and enter access code 17823fep or contact the ARAG Customer Care Center at 1-800-255-9509. Please reference FEP or 17823 when contacting the ARAG Customer Care Center.

DIY Docs™

Members also have the opportunity to purchase a **DIY Docs** package for a low annual subscription rate of $69.95 (30% off the $99 retail rate). DIY Docs members receive access to more than 300 legally-valid documents. These documents are authored and reviewed by attorneys for accuracy and to ensure they are legally valid in all 50 states. Available DIY Docs include a Will, Living Will, Powers of Attorney, Medical Authorization for a Minor, Bill of Sale, Contract, Residential Lease, and much more.

The DIY Docs package includes an easy-to-use document assembly tool that enables members to create, update, store, and print documents at any time. For more information or to purchase DIY Docs, visit www.fepblue.org, Benefits + Services, select the ARAG Legal Center link, and enter access code 17823fep or contact the ARAG Customer Care Center at 1-800-255-9509. Please reference FEP or 17823 when contacting the ARAG Customer Care Center.

TruHearing® MemberPlus® Hearing Aid Program

TruHearing® MemberPlus® offers low, guaranteed pricing on hearing aids through a nation-wide network of more than 3,100 providers. Over 90 state-of-the-art products are available from five of the world's leading manufacturers. The average savings is $1,780 per pair when compared to national retail prices. Service Benefit Plan members can choose from dozens of top digital hearing aids and pay $0 out-of-pocket per pair by using the TruHearing MemberPlus Program together with their regular hearing aid coverage (see page 56 of this brochure for benefit details). The MemberPlus enrollment fee is waived for Service Benefit Plan members through December 31, 2014 (a $108 value). TruHearing gives customers a 45-day money-back guarantee and a 3-year manufacturer warranty on all hearing aid purchases. Call 1-877-360-2436 to schedule an appointment or visit www.fepblue.org for additional information. All appointments must be scheduled through TruHearing.

Note: TruHearing will submit your claim to the Service Benefit Plan. You are responsible for any balances.

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 we determine 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 (*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 that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States.
- Services, drugs, or supplies billed by Preferred and Member facilities for inpatient care related to specific medical errors and hospital-acquired conditions known as Never Events (see definition on page 144).
- Experimental or investigational procedures, treatments, drugs, or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations, sexual dysfunction, or sexual inadequacy (except for surgical placement of penile prostheses to treat erectile dysfunction).
- Services, drugs, or supplies you receive from a provider or facility barred or suspended from the FEHB Program.
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services, drugs, or supplies you receive without charge while in active military service.
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 139), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 140), or state premium taxes however applied.
- Services or supplies ordered, performed, or furnished by you or your immediate relatives or household members, such as spouse, parents, children, brothers, or sisters by blood, marriage, or adoption.
- Services or supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs; oxygen; and physical, speech, and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits.
- Services, drugs, or supplies you receive from noncovered providers.
- Services, drugs, or supplies you receive for cosmetic purposes.
- Services, drugs, or supplies for the treatment of obesity, weight reduction, or dietary control, except for office visits and diagnostic tests for the treatment of obesity; gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures for the treatment of morbid obesity (see pages 63 and 64); and those nutritional counseling services specifically listed on pages 37, 42, 45, and 79.
- Services you receive from a provider that are outside the scope of the provider's licensure or certification.
- Any dental or oral surgical procedures or drugs involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for the fitting or continued use of dentures, except as specifically described in Section 5(g), *Dental benefits*, and Section 5(b) under *Oral and maxillofacial surgery*.
- Orthodontic care for malposition of the bones of the jaw or for temporomandibular joint (TMJ) syndrome.
- Services of standby physicians.
- Self-care or self-help training.
- Custodial or long term care (see *Definitions*).
- Personal comfort items such as beauty and barber services, radio, television, or telephone.
- Furniture (other than medically necessary durable medical equipment) such as commercial beds, mattresses, chairs.

- Routine services, such as periodic physical examinations; screening examinations; immunizations; and services or tests not related to a specific diagnosis, illness, injury, set of symptoms, or maternity care, except for those preventive services specifically covered under Preventive care, adult and child in Sections 5(a) and 5(c), the preventive screenings specifically listed on pages 41-45 and page 84; and certain routine services associated with covered clinical trials (see page 134).
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay.
- Applied behavior analysis (ABA) or ABA therapy.
- Topical Hyperbaric Oxygen Therapy (THBO).
- Research costs (costs related to conducting a clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes).
- Professional charges for after-hours care, except when associated with services provided in a physician's office.
- Incontinence products such as incontinence garments (including adult or infant diapers, briefs, and underwear), incontinence pads/liners, bed pads, or disposable washcloths.
- Services not specifically listed as covered.

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 precertification or prior approval), including urgent care claims procedures.

How to claim benefits

To obtain claim forms or other claims filing advice, or answers to your questions about our benefits, contact us at the customer service number on the back of your Service Benefit Plan ID card, or at our Web site at www.fepblue.org.

In most cases, physicians and facilities file claims for you. Just present your Service Benefit Plan ID card when you receive services. Your physician must file on the CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form.

When you must file a claim – such as when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Use a separate claim form for each family member. For long or continuing hospital stays, or other long-term care, you should submit claims at least every 30 days. Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number, and relationship to enrollee
- Patient's Plan identification number
- Name and address of person or company providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- Charge for each service or supply

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

In addition:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor [such as the Medicare Summary Notice (MSN)] with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- If your claim is for the rental or purchase of durable medical equipment, home nursing care, or physical, occupational, or speech therapy, you must provide a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for dental care to repair accidental injury to sound natural teeth should include documentation of the condition of your teeth before the accidental injury, documentation of the injury from your provider(s), and a treatment plan for your dental care. We may request updated treatment plans as your treatment progresses.
- Claims for prescription drugs and supplies that are not received from the Retail Pharmacy Program, through the Mail Service Prescription Drug Program, or through the Specialty Drug Pharmacy Program must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, and charge. (See pages 128-129 for information on how to obtain benefits from the Retail Pharmacy Program, the Mail Service Prescription Drug Program, and the Specialty Drug Pharmacy Program.)

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.

Prescription drug claims

Preferred Retail Pharmacies – When you use Preferred retail pharmacies, show your Service Benefit Plan ID card. Preferred retail pharmacies will file your claims for you. To use Preferred retail pharmacies with online ordering options that include home delivery, go to our Web site, www.fepblue.org, visit the "Pharmacy" page, and click on the "Retail Pharmacy" link for your enrollment option (Standard or Basic) to fill your prescriptions. Be sure to have your Service Benefit Plan ID card ready to complete your purchase. We reimburse the Preferred retail pharmacy for your covered drugs and supplies. You pay the applicable coinsurance or copayment.

Note: Even if you use Preferred pharmacies, you will have to file a paper claim form to obtain reimbursement if:

- You do not have a valid Service Benefit Plan ID card;
- You do not use your valid Service Benefit Plan ID card at the time of purchase; or
- You did not obtain prior approval when required (see page 24).

See the following paragraph for claim filing instructions.

Non-Preferred Retail Pharmacies

Standard Option: You must file a paper claim for any covered drugs or supplies you purchase at Non-preferred retail pharmacies. Contact your Local Plan or call 1-800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired members with TDD equipment may call 1-800-624-5077. Follow the instructions on the prescription drug claim form and submit the completed form to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.

Basic Option: There are **no benefits** for drugs or supplies purchased at Non-preferred retail pharmacies.

Mail Service Prescription Drug Program

Standard Option: We will send you information on our Mail Service Prescription Drug Program, including an initial mail order form. To use this program:

(1) Complete the initial mail order form;

(2) Enclose your prescription and copayment;

(3) Mail your order to CVS Caremark, P.O. Box 1590, Pittsburgh, PA 15230-1590; and

(4) Allow up to two weeks for delivery.

Alternatively, your physician may call in your initial prescription at 1-800-262-7890 (TDD: 1-800-216-5343). You will be billed later for the copayment.

After that, to order refills either call the same number or access our Web site at www.fepblue.org and either charge your copayment to your credit card or have it billed to you later. Allow up to ten (10) days for delivery on refills.

Note: Specialty drugs will not be dispensed through the Mail Service Prescription Drug Program. See page 129 for information about the Specialty Drug Pharmacy Program.

Basic Option: The Mail Service Prescription Drug Program **is not** available under Basic Option.

Specialty Drug Pharmacy Program

Standard and Basic Options: If your physician prescribes a specialty drug that appears on our Service Benefit Plan Specialty Drug List, your physician may order the initial prescription by calling our Specialty Drug Pharmacy Program at 1-888-346-3731 (TDD: 1-877-853-9549), or you may send your prescription to: Specialty Drug Pharmacy Program, CVS Caremark, P.O. Box 1590, Pittsburgh, PA 15230-1590. You will be billed later for the copayment. The Specialty Drug Pharmacy Program will work with you to arrange a delivery time and location that is most convenient for you. To order refills, call the same number to arrange your delivery. You may either charge your copayment to your credit card or have it billed to you later.

Note: For the most up-to-date listing of covered specialty drugs, call the Specialty Drug Pharmacy Program at 1-888-346-3731 (TDD: 1-877-853-9549), or visit our Web site, www.fepblue.org.

Records

Keep a separate record of the medical expenses of each covered family member, because deductibles (under Standard Option) and benefit maximums (such as those for outpatient physical therapy or preventive dental care) apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible under Standard Option. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us your claim and appropriate documentation 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 you submitted the claim as soon as reasonably possible. If we return a claim or part of a claim for additional information, you must resubmit it within 90 days, or before the timely filing period expires, whichever is later.

Note: Once we pay benefits, there is a five-year limitation on the re-issuance of uncashed checks.

Overseas claims

Please refer to the claims filing information on pages 121 and 122 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

The Secretary of Health and Human Services has identified counties where at least 10 percent of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo, and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable 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 code and its corresponding meaning, and the procedure or treatment code and its corresponding meaning.

Section 8. The disputed claims process

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, drugs, or supplies that must have precertification (such as inpatient hospital admissions) or prior approval from the Plan.

You may be able to appeal directly to the U.S. 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.fepblue.org.

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 call us at the customer service number on the back of your Service Benefit Plan ID card, or send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program, Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program).

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

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

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

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

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 the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program, Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program); 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. 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 3.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

The disputed claims process *(continued)*

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

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information – if we did not send you a decision within 30 days after we received the additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 1, 1900 E Street, NW, Washington, DC 20415-3610.

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 determine if we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send you a final decision within 60 days. There are no other administrative appeals.

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at the customer service number on the back of your Service Benefit Plan ID card. 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 1 at (202) 606-0727 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 group 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 example:

- If you are covered under our Plan as a dependent, any group health insurance you have from your employer will pay primary and we will pay secondary.
- If you are an annuitant under our Plan and also are actively employed, any group health insurance you have from your employer will pay primary and we will pay secondary.
- When you are entitled to the payment of health care expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payor and we are the secondary payor.

For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC Web site at http://www.NAIC.org.

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

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. For example, we will generally only make up the difference between the primary payor's benefits payment and 100% of the Plan allowance, subject to our applicable deductible (under Standard Option) and coinsurance or copayment amounts, except when Medicare is the primary payor (see page 140). Thus, it is possible that the combined payments from both plans may not equal the entire amount billed by the provider.

Note: When we pay secondary to primary coverage you have from a prepaid plan (HMO), we base our benefits on your out-of-pocket liability under the prepaid plan (generally, the prepaid plan's copayments), subject to our deductible (under Standard Option) and coinsurance or copayment amounts.

In certain circumstances when we are secondary and there is no adverse effect on you (that is, you do not pay any more), we may also take advantage of any provider discount arrangements your primary plan may have and only make up the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan.

Note: Any visit limitations that apply to your care under this Plan are still in effect when we are the secondary payor.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage, and you must also send us documents about your other coverage if we ask for them.

Please see Section 4, *Your costs 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 a 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 paid 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 paid benefits for that injury, you must agree to the following provisions:

- All recoveries you or your representatives obtain (whether by lawsuit, settlement, insurance or benefit program claims, 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 your representatives. For purposes of this provision, "you" includes your covered dependents, and "your representatives" include, if applicable, your heirs, administrators, legal representatives, parents (if you are a minor), successors, or assignees. This is our right of recovery.
- We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. Our right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.
- We will not reduce our share of any recovery unless, in the exercise of our discretion, we agree in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.
- You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must not take any action that may prejudice 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 you do seek damages for your illness or injury, you must tell us promptly that you have made a claim against another party for a condition that we have paid or may pay benefits for, you must seek recovery of our benefit payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a first priority 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 sign a reimbursement agreement and/or 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 signed reimbursement agreement and/or assignment, and we may enforce our right of recovery by offsetting future benefits.

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

Our rights of recovery and subrogation as described in this Section may be enforced, at the Carrier's option, by the Carrier, by any of the Local Plans that administered the benefits paid in connection with the injury or illness at issue, or by any combination of these entities.

Among the other situations covered by this provision, the circumstances in which we may subrogate or assert a right of recovery shall also include:

- When a third party injures you, for example, in an automobile accident or through medical malpractice;
- When you are injured on premises owned by a third party; or
- When you 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:
  - No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by you to treat those benefits as secondary to this Plan
  - Uninsured and underinsured motorist coverage
  - 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)

Some FEHB plans already cover some dental and vision services. When you are covered by more than one dental/vision plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

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

- **Routine care costs** – costs for medically necessary 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. We provide benefits for these types of costs at the benefit levels described in Section 5 (*Benefits*) when the services are covered under the Plan and we determine that they are medically necessary.

- **Extra care costs** – costs of covered services 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 covers extra care costs related to taking part in an approved clinical trial for a covered stem cell transplant such as additional tests that a patient may need as part of the clinical trial protocol, but not as part of the patient's routine care. For more information about approved clinical trials for covered stem cell transplants, see pages 72-73. Extra care costs related to taking part in any other type of clinical trial are not covered. We encourage you to contact us at the customer service number on the back of your ID card to discuss specific services if you participate in a clinical trial.

- **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.

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.

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 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048), 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 page 137.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213, (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, (TTY 1-800-325-0778), 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 do not 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 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.

(Please refer to page 139 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)

• The Original Medicare Plan (Part A or Part B)

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

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. For example, you must continue to obtain prior approval for some prescription drugs and organ/tissue transplants before we will pay benefits. However, you do not have to precertify inpatient hospital stays when Medicare Part A is primary (see page 23 for exception).

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

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

When the Original Medicare Plan 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 the covered charges. To find out if you need to do something to file your claims, call us at the customer service number on the back of your Service Benefit Plan ID card or visit our Web site at www.fepblue.org.

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

When Medicare Part A is primary –

- Under **Standard Option**, we will waive our:
  - Inpatient hospital per-admission copayments; and
  - Inpatient Member and Non-member hospital coinsurance.
- Under **Basic Option**, we will waive our:
  - Inpatient hospital per-day copayments.

Note: Once you have exhausted your Medicare Part A benefits:

- Under **Standard Option**, you must then pay any difference between our allowance and the billed amount at Non-member hospitals.
- Under **Basic Option**, you must then pay the inpatient hospital per-day copayments.

When Medicare Part B is primary –

- Under **Standard Option**, we will waive our:
  - Calendar year deductible;
  - Coinsurance and copayments for inpatient and outpatient services and supplies provided by physicians and other covered health care professionals; and
  - Coinsurance for outpatient facility services.
- Under **Basic Option**, we will waive our:
  - Copayments and coinsurance for care received from covered professional and facility providers.

Note: We do not waive benefit limitations, such as the 25-visit limit for home nursing visits. In addition, we do not waive any coinsurance or copayments for prescription drugs.

You can find more information about how our Plan coordinates benefits with Medicare in our *Medicare and You Guide for Federal Employees* available online at www.fepblue.org.

- **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.

- **Private contract with your physician**

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048), 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. 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.

Under Standard Option, 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, but we will not waive any of our copayments, coinsurance, or deductibles, if you receive services from providers who do not participate in the Medicare Advantage plan.

Under Basic Option, we provide benefits for care received from Preferred providers when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area. However, we will not waive any of our copayments or coinsurance for services you receive from Preferred providers who do not participate in the Medicare Advantage plan. Please remember that you must receive care from Preferred providers in order to receive Basic Option benefits. See page 21 for the exceptions to this requirement.

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 prescription drug coverage (Part B)**

This health plan **does not** coordinate its prescription drug benefits with Medicare Part B.

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 the 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.

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

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

If you:

are age 65 or over; and

do not have Medicare Part A, Part B, or both; and

have this Plan as an annuitant or as a former spouse, **or** as a family member of an annuitant or former spouse; and

are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care:

The law requires us to base our payment on an amount – the "equivalent Medicare amount" – set by Medicare's rules for what Medicare would pay, not on the actual charge.

You are responsible for your deductible (Standard Option only), coinsurance, or copayments under this Plan.

You are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you.

The law prohibits a hospital from collecting more than the equivalent Medicare amount.

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

an amount set by Medicare and called the "Medicare approved amount," or

the actual charge if it is lower than the Medicare approved amount.

If your physician:	**Then you are responsible for:**	
Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network	Standard Option:	your deductibles, coinsurance, and copayments.
	Basic Option:	your copayments and coinsurance.
Participates with Medicare or accepts Medicare assignment and is **not** in our Preferred network	Standard Option:	your deductibles, coinsurance, and copayments, and any balance up to the Medicare approved amount.
	Basic Option:	all charges.
Does not participate with Medicare, and is in our Preferred network	Standard Option:	your deductibles, coinsurance, and copayments, and any balance up to 115% of the Medicare approved amount.
	Basic Option:	your copayments and coinsurance, and any balance up to 115% of the Medicare approved amount.
		Note: In many cases, your payment will be less because of our Preferred agreements. Contact your Local Plan for information about what your specific Preferred provider can collect from you.
Does not participate with Medicare and is **not** in our Preferred network	Standard Option:	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.
	Basic Option:	all charges.

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

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

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

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays.

Note: We pay our regular benefits for emergency services to a facility provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

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

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

- If your physician **accepts** Medicare assignment, then you pay nothing for covered charges (see note below for Basic Option).
- If your physician **does not accept** Medicare assignment, then you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment (see note below for Basic Option).

Note: **Under Basic Option,** you must see **Preferred** providers in order to receive benefits. See page 21 for the exceptions to this requirement.

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

Section 10. Definitions of terms we use in this brochure

Accidental injury

An injury caused by an external force or element such as a blow or fall that requires immediate medical attention, including animal bites and poisonings. ***Note:*** Injuries to the teeth while eating are **not** considered accidental injuries. Dental care for accidental injury is limited to dental treatment necessary to repair sound natural teeth.

Admission

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

Agents

Medicines and other substances or products given by mouth, inhaled, placed on you, or injected in you to diagnose, evaluate, and/or treat your condition. Agents include medicines and other substances or products necessary to perform tests such as bone scans, cardiac stress tests, CT Scans, MRIs, PET Scans, lung scans, and X-rays, as well as those injected into the joint.

Assignment

An authorization by the enrollee or spouse for us to issue payment of benefits directly to the provider. We reserve the right to pay you, the enrollee, directly for all covered services.

Assisted reproductive technology (ART)

Fertility treatments in which both eggs and sperm are manipulated. In general, assisted reproductive technology (ART) procedures involve retrieval of eggs from a woman's ovaries, combining them with sperm in the laboratory, and returning them to the woman's body or donating them to another woman.

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.

Carrier

The Blue Cross and Blue Shield Association, on behalf of the local Blue Cross and Blue Shield Plans.

Case management

A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's health needs through communication and available resources to promote quality, cost-effective outcomes (Case Management Society of America, 2012). Each Blue Cross and Blue Shield Plan administers a case management program to assist Service Benefit Plan members with certain complex and/or chronic health issues. Each program is staffed by licensed health care professionals (Case Managers) and is accredited by URAC or NCQA. For additional information regarding case management, call us at the telephone number listed on the back of your Service Benefit Plan ID card.

Clinical trials cost categories

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

- Routine care costs – costs for medically necessary 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

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.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 27.

Concurrent care claims

A claim involving 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 as an appealable decision. 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. See pages 25 and 26 in Section 3.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 27.

Cosmetic surgery

Any surgical procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form, except for repair of accidental injury, or to restore or correct a part of the body that has been altered as a result of disease or surgery or to correct a congenital anomaly.

Cost-sharing

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

Covered services

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

Custodial or long term care

Facility-based care that does not require access to the full spectrum of services performed by licensed health care professionals that is available 24 hours-a-day in acute inpatient hospital settings to avoid imminent, serious, medical or psychiatric consequences. By "facility-based," we mean services provided in a hospital, long term care facility, extended care facility, skilled nursing facility, residential treatment facility, school, halfway house, group home, or any other facility providing skilled or unskilled treatment or services to individuals whose conditions have been stabilized. Custodial or long term care can also be provided in the patient's home, however defined.

Custodial or long term care may include services that a person not medically skilled could perform safely and reasonably with minimal training, or that mainly assist the patient with daily living activities, such as:

1. Personal care, including help in walking, getting in and out of bed, bathing, eating (by spoon, tube, or gastrostomy), exercising, or dressing;
2. Homemaking, such as preparing meals or special diets;
3. Moving the patient;
4. Acting as companion or sitter;
5. Supervising medication that can usually be self-administered; or
6. Treatment or services that any person can perform with minimal instruction, such as recording pulse, temperature, and respiration; or administration and monitoring of feeding systems.

We do not provide benefits for custodial or long term care, regardless of who recommends the care or where it is provided. The Carrier, its medical staff, and/or an independent medical review determine which services are custodial or long term care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies in a calendar year before we start paying benefits for those services. See page 27.

Diagnostic service

An examination or test of an individual with signs, symptoms, or a probability of having a specific disease to determine the presence of that disease; or an examination or test to evaluate the course of treatment for a specific disease.

Durable medical equipment

Equipment and supplies that:

1. Are prescribed by your physician (i.e., the physician who is treating your illness or injury);
2. Are medically necessary;
3. Are primarily and customarily used only for a medical purpose;
4. Are generally useful only to a person with an illness or injury;
5. Are designed for prolonged use; and
6. Serve a specific therapeutic purpose in the treatment of an illness or injury.

Experimental or investigational services

Experimental or investigational shall mean:

a. A drug, device, or biological product that 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; or

b. Reliable evidence shows that the health care service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

c. Reliable evidence shows that the consensus of opinion among experts regarding the health care service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) 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; or

d. Reliable evidence shows that the health care service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) does not improve net health outcome, is not as beneficial as any established alternatives, or does not produce improvement outside of the research setting.

Reliable evidence shall mean only evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and physician specialty society recommendations, such as:

a. Published reports and articles in the authoritative medical and scientific literature;

b. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or

c. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or biological product or medical treatment or procedure.

Generic alternative

A generic alternative is an FDA-approved generic drug in the same class or group of drugs as your brand-name drug. The therapeutic effect and safety profile of a generic alternative are similar to your brand-name drug, but it has a different active ingredient.

Generic equivalent

A generic equivalent is a drug whose active ingredients are identical in chemical composition to those of its brand-name counterpart. Inactive ingredients may not be the same. A generic drug is considered "equivalent," if it has been approved by the FDA as interchangeable with your brand-name drug.

Group health coverage

Health care coverage that you are eligible for based on your employment, or your membership in or connection with a particular organization or group, that provides payment for medical services or supplies, or that pays a specific amount of more than $200 per day for hospitalization (including extension of any of these benefits through COBRA).

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law. See pages 18-19 for information about how we determine which health care professionals are covered under this Plan.

Health Risk Assessment (HRA)

A questionnaire designed to assess your overall health and identify potential health risks. Service Benefit Plan members have access to the Blue Cross and Blue Shield HRA (called the "Blue Health Assessment") which is supported by a computerized program that analyzes your health and lifestyle information and provides you with a personal and confidential health action plan that is protected by HIPAA privacy and security provisions. Results from the Blue Health Assessment include practical suggestions for making healthy changes and important health information you may want to discuss with your health care provider. For more information, visit our Web site, www.fepblue.org.

Intensive outpatient care

A comprehensive, structured outpatient treatment program that includes extended periods of individual or group therapy sessions designed to assist members with mental health and/or substance abuse conditions. It is an intermediate setting between traditional outpatient therapy and partial hospitalization, typically performed in an outpatient facility or outpatient professional office setting. Program sessions may occur more than one day per week. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Local Plan

A Blue Cross and/or Blue Shield Plan that serves a specific geographic area.

Medical foods

The term medical food, as defined in Section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." In general, to be considered a medical food, a product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the product must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and the product must be intended to be used under medical supervision.

Medically underserved areas (MUAs)

Each year, OPM determines which states are "medically underserved" using criteria established by Federal regulation. These are states in which 25 percent or more of the residents are located in areas with a shortage of primary medical care providers. For 2014, the states are: Alabama, Arizona, Idaho, Illinois, Louisiana, Mississippi, Missouri, New Mexico, North Dakota, Oklahoma, South Carolina, and Wyoming. Under this Plan, coverage of medical practitioners is not determined by your state's designation as a Medically Underserved Area (MUA). We cover any licensed medical practitioner for covered services performed within the scope of that license, as required by Section 2706(a) of the Public Health Service Act (PHSA). See pages 18-19 for more information.

Medical necessity

All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine that the criteria for medical necessity are met. Medical necessity shall mean health care services that a physician, hospital, or other covered professional or facility provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

a. In accordance with generally accepted standards of medical practice in the United States; and
b. Clinically appropriate, in terms of type, frequency, extent, site, and duration; and considered effective for the patient's illness, injury, disease, or its symptoms; and
c. Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury, or disease, or its symptoms; and
d. Not part of or associated with scholastic education or vocational training of the patient; and
e. In the case of inpatient care, only provided safely in the acute inpatient hospital setting.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and physician specialty society recommendations.

The fact that one of our covered physicians, hospitals, or other professional or facility providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.

Mental conditions/ substance abuse

Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD; or disorders listed in the ICD requiring treatment for abuse of, or dependence upon, substances such as alcohol, narcotics, or hallucinogens.

Never Events

Errors in medical care that are clearly identifiable, preventable, and serious in their consequences, such as surgery performed on a wrong body part, and specific conditions that are acquired during your hospital stay, such as severe bed sores.

Observation services

Hospital outpatient services ordered by the physician to assess whether the member needs to be admitted as an inpatient or can be discharged. If you are in the hospital more than a few hours, always ask your physician or the hospital staff if your stay is considered inpatient or outpatient. Although you may stay overnight in a hospital room and receive meals and other hospital services, some hospital services – including "**observation services**" – are actually outpatient care. Since observation services are billed as outpatient care, outpatient facility benefit levels apply and your out-of-pocket expenses may be higher as a result.

Partial hospitalization

An intensive facility-based treatment program during which an interdisciplinary team provides care related to mental health and/or substance abuse conditions. Program sessions may occur more than one day per week and may be full or half days, evenings, and/or weekends. The duration of care per session is less than 24 hours. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your cost-share for covered services. Fee-for-service plans determine their allowances in different ways. If the amount your provider bills for covered services is less than our allowance, we base your share (coinsurance, deductible, and/or copayments), on the billed amount. We determine our allowance as follows:

- **PPO providers –** Our allowance (which we may refer to as the "PPA" for "Preferred Provider Allowance") is the negotiated amount that Preferred providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with each local Blue Cross and Blue Shield Plan, and retail pharmacies that contract with CVS Caremark) have agreed to accept as payment in full, when we pay primary benefits.

  Our PPO allowance includes any known discounts that can be accurately calculated at the time your claim is processed. For PPO facilities, we sometimes refer to our allowance as the "Preferred rate." The Preferred rate may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost-sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf. (See page 113 for special information about limits on the amounts Preferred dentists can charge you under Standard Option.)
- **Participating providers –** Our allowance (which we may refer to as the "PAR" for "Participating Provider Allowance") is the negotiated amount that these providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with some local Blue Cross and Blue Shield Plans) have agreed to accept as payment in full, when we pay primary benefits. For facilities, we sometimes refer to our allowance as the "Member rate." The member rate includes any known discounts that can be accurately calculated at the time your claim is processed, and may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost-sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf.
- **Non-participating providers –** We have no agreements with these providers to limit what they can bill you for their services. **This means that using Non-participating providers could result in your having to pay significantly greater amounts for the services you receive.** We determine our allowance as follows:
  - For inpatient services at hospitals, and other facilities that do not contract with your local Blue Cross and Blue Shield Plan ("Non-member facilities"), our allowance is based on the average amount paid nationally on a per day basis to contracting and non-contracting facilities for covered room, board, and ancillary charges for your type of admission. If you would like additional information, or to obtain the current allowed amount, please call the customer service number on the back of your ID card. For inpatient stays resulting from medical emergencies or accidental injuries, or for routine deliveries, our allowance is the billed amount;

- For outpatient, non-emergency surgical services at hospitals and other facilities that do not contract with your local Blue Cross and Blue Shield Plan ("Non-member facilities"), our allowance is the average amount for all outpatient surgical claims combined that we pay nationally to contracting and non-contracting facilities. This allowance applies to all of the covered surgical services billed by the hospital and is the same regardless of the type of surgery performed. If you plan on using a Non-member hospital, or other Non-member facility, for your outpatient surgical procedure, please call us before your surgery at the customer service number on the back of your ID card to obtain the current allowed amount and assistance in estimating your total out-of-pocket expenses.

  Please keep in mind that Non-member facilities may bill you for any difference between the allowance and the billed amount. You may be able to reduce your out-of-pocket expenses by using a Preferred hospital for your outpatient surgical procedure. To locate a Preferred provider, go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder, or call us at the customer service number on the back of your ID card;
- For other outpatient services by Non-member facilities, and for outpatient surgical services resulting from a medical emergency or accidental injury that are billed by Non-member facilities, our allowance is the billed amount (minus any amounts for noncovered services);
- For physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greater of 1) the Medicare participating fee schedule amount or the Medicare Part B Drug Average Sale Price (ASP) for the service, drug, or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount or ASP) or 2) 100% of the Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained. Local Plans determine the UCR amount in different ways. Contact your Local Plan if you need more information. We may refer to our allowance for Non-participating providers as the "NPA" (for "Non-participating Provider Allowance");
- For emergency medical services performed in the emergency department of a hospital provided by physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greatest of 1) the Medicare participating fee schedule amount or the Medicare Part B Drug Average Sale Price (ASP) for the service, drug, or supply in the geographic area in which it was performed or obtained; or 2) 100% of the Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained; or 3) an allowance based on equivalent Preferred provider services that is calculated in compliance with the Affordable Care Act;
- For prescription drugs furnished by retail pharmacies that do not contract with CVS Caremark, our allowance is the average wholesale price ("AWP") of a drug on the date it is dispensed, as set forth by Medi-Span® in its national drug data file; and
- For services you receive outside of the United States, Puerto Rico, and the U.S. Virgin Islands from providers that do not contract with us or with AXA Assistance, we use our Overseas Fee Schedule to determine our allowance. Our fee schedule is based on a percentage of the amounts we allow for Non-participating providers in the Washington, DC, area.

Important notice about Non-participating providers!

Note: **Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive.** Non-participating and Non-member providers are under no obligation to accept our allowance as payment in full. If you use Non-participating and/or Non-member providers, you will be responsible for any difference between our payment and the billed amount (except in certain circumstances involving covered Non-participating professional care – see page 147). In addition, you will be responsible for any applicable deductible, coinsurance, or copayment. You can reduce your out-of-pocket expenses by using Preferred providers whenever possible. To locate a Preferred provider, go to www.fepblue.org and select "Provider Directory" to use our National Doctor & Hospital Finder, or call us at the customer service number on the back of your ID card. We encourage you to always use Preferred providers for your care.

Note: For **certain** covered services from Non-participating professional providers, your responsibility for the difference between the Non-participating Provider Allowance (NPA) and the billed amount may be limited.

In **only** those situations listed below, when the difference between the NPA and the billed amount for covered Non-participating professional care is greater than $5,000 for an episode of care, your responsibility will be limited to $5,000 (in addition to any applicable deductible, coinsurance, or copayment amounts). An episode of care is defined as all covered Non-participating professional services you receive during an emergency room visit, an outpatient visit, or a hospital admission (including associated emergency room or pre-admission services), plus your first follow-up outpatient visit to the Non-participating professional provider(s) who performed the service(s) during your hospital admission or emergency room visit.

- When you receive care in a Preferred hospital from Non-participating professional providers such as a radiologist, anesthesiologist, certified registered nurse anesthetist (CRNA), pathologist, neonatologist, or pediatric sub-specialist; and the professional providers are hospital-based or are specialists recruited from outside the hospital either without your knowledge and/or because they are needed to provide immediate medical or surgical expertise; and
- When you receive care from Non-participating professional providers in a Preferred, Member, or Non-member hospital as a result of a medical emergency or accidental injury (see pages 90-93).

For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see page 31 and pages 121-122.

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.

Precertification

The requirement to contact the local Blue Cross and Blue Shield Plan serving the area where the services will be performed before being admitted to the hospital for inpatient care, or within two business days following an emergency admission.

Preferred provider organization (PPO) arrangement

An arrangement between Local Plans and physicians, hospitals, health care institutions, and other covered health care professionals (or for retail pharmacies, between pharmacies and CVS Caremark) to provide services to you at a reduced cost. The PPO provides you with an opportunity to reduce your out-of-pocket expenses for care by selecting your facilities and providers from among a specific group. PPO providers are available in most locations; using them whenever possible helps contain health care costs and reduces your out-of-pocket costs. The selection of PPO providers is solely the Local Plan's (or for pharmacies, CVS Caremark's) responsibility. We cannot guarantee that any specific provider will continue to participate in these PPO arrangements.

Pre-service claims

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

Preventive Care, Adult

Adult preventive care includes the following services: preventive office visits and exams [including health screening services to measure height, weight, blood pressure, heart rate, and Body Mass Index (BMI)]; chest X-ray; EKG; general health panel; basic or comprehensive metabolic panel; fasting lipoprotein profile; urinalysis; CBC; screening for alcohol/substance abuse; counseling on reducing health risks; screening for depression; screening for chlamydia, syphilis, gonorrhea, HPV, and HIV; administration and interpretation of a Health Risk Assessment questionnaire; cancer screenings and screening for abdominal aortic aneurysms as specifically stated in this brochure; and routine immunizations as licensed by the U.S. Food and Drug Administration (FDA).

Prior approval

Written assurance that benefits will be provided by:

1. The Local Plan where the services will be performed; or
2. The Retail Pharmacy Program, the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program.

For more information, see the benefit descriptions in Section 5 and *Other services* in Section 3, under *You need prior Plan approval for certain services*, on pages 23-24.

Residential treatment centers

Residential treatment centers (RTCs) are live-in facilities (although not licensed as hospitals) that offer treatment for a variety of addiction, behavioral, and emotional problems. These programs may include drug and alcohol treatment, confidence building, military-style discipline, and psychological counseling. Many of the programs are intended to provide a less-restrictive alternative to incarceration or hospitalization, or to offer intervention for troubled individuals. RTC programs are often designed to treat children and adolescents and have been described in a variety of ways, including "therapeutic boarding schools," "behavioral modification facilities," "emotional growth academies," and "boot camps."

No standardized definitions exist for RTCs or for the programs they administer. RTC programs are not regulated by the Federal government. Although some RTCs may meet state licensing requirements and standards, certain types of residential facilities are exempt from licensing or monitoring by the state. Accreditation of these facilities, their clinicians, and staff members varies significantly from state to state.

Benefits are not available for services performed or billed by RTCs. If you have questions about treatment at an RTC, please contact us at the customer service number listed on the back of your ID card.

Routine services

Services that are not related to a specific illness, injury, set of symptoms, or maternity care (other than those routine costs associated with a clinical trial as defined on pages 73 and 141).

Screening service

An examination or test of an individual with no signs or symptoms of the specific disease for which the examination or test is being done, to identify the potential for that disease and prevent its occurrence.

Sound natural tooth

A tooth that is whole or properly restored (restoration with amalgams or resin-based composite fillings only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.

Specialty drugs

Pharmaceutical products that are included on the Service Benefit Plan Specialty Drug List that are typically high in cost and have one or more of the following characteristics:

- Injectable, infused, inhaled, or oral therapeutic agents, or products of biotechnology
- Complex drug therapy for a chronic or complex condition, and/or high potential for drug adverse effects
- Specialized patient training on the administration of the drug (including supplies and devices needed for administration) and coordination of care is required prior to drug therapy initiation and/or during therapy
- Unique patient compliance and safety monitoring requirements
- Unique requirements for handling, shipping, and storage

Transplant period

A defined number of consecutive days associated with a covered organ/tissue transplant procedure.

Urgent care claims

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 using the number on the back of your Service Benefit Plan ID card and tell us the claim is urgent. 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/Our

"Us," "we," and "our" refer to the Blue Cross and Blue Shield Service Benefit Plan, and the local Blue Cross and Blue Shield Plans that administer it.

You/Your

"You" and "your" refer to the enrollee (the contract holder eligible for enrollment and coverage under the Federal Employees Health Benefits Program and enrolled in the Plan) and each covered family member.

Section 11. Other Federal Programs

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

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA) –** Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, **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) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

  Note: If you are enrolled in the HCFSA, you can take advantage of the Paperless Reimbursement option, which allows you to be reimbursed from your HCFSA without submitting an FSAFEDS claim. When the Blue Cross and Blue Shield Service Benefit Plan receives a claim for benefits, the Plan forwards information about your out-of-pocket expenses (such as copayment and deductible amounts) to FSAFEDS for processing. FSAFEDS then reimburses you for your eligible out-of-pocket costs – there's no need for a claim form or receipt! Reimbursement is made directly to your bank from your HCFSA account via Electronic Funds Transfer. You may need to file a paper claim to FSAFEDS in certain situations. Visit www.FSAFEDS.com for more information. FSAFEDS is not part of the Service Benefit 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 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) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

- **Dependent Care FSA (DCFSA) –** Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

- 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 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time.
TTY: 1-800-952-0450.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is 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. Beginning in 2014, most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**

Vision Insurance

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

Additional Information

You can find a comparison of the plans available and their premiums on the OPM Web sites at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's Web site, where you can view detailed information about benefits and preferred providers.

How do I enroll?

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

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility, or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY 1-800-843-3557), or visit www.ltcfeds.com.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear. This Index is not an official statement of benefits.

Accidental injury, 21, 23, 53, 66, 67, 78, 89, 90-93, 112, 127, 141, 142, 145, 146, 147
Acupuncture, 46, 60, 76
Affordable Care Act (ACA), 9, 12, 41, 45, 104, 146
Allergy testing, 50
Allogeneic transplants, 20, 21, 23, 69-75
Ambulance, 21, 77, 89, 90, 93
Anesthesia, 30, 46, 62, 76, 79, 81, 112, 116
Autologous transplants, 20, 21, 23, 68, 71-74
Average wholesale price (AWP), 106, 146
Biopsies, 63, 81
Birthing centers, 20, 46, 79, 82, 83, 84
Blood and blood plasma, 58, 79, 81
Blood or marrow stem cell transplants, 20, 21, 23, 68-75
Blue Distinction Centers, 20
  for Transplants, 20-21, 70, 71, 72, 75
Blue Health Assessment, 41, 109, 118, 119, 143
Breastfeeding support and supplies, 46, 48
Breast pump kit, 47
Breast reconstruction, 66
Cancer tests, 42
Cardiac rehabilitation, 20, 51, 83
Case management, 73, 86, 94, 120, 141
Casts, 63, 65, 79, 81
Catastrophic protection, 31-32
Certificate of Group Health Plan Coverage, 12
CHAMPVA, 132
Chemotherapy, 51, 81
Chiropractic manipulative treatment, 60
Cholesterol tests, 41, 147
Circumcision, 47, 63
Claims and claims filing, 127-129
Cognitive rehabilitation therapy, 52, 83
Coinsurance, 27, 141
Colorectal cancer tests, 42
Confidentiality, 14
Congenital anomalies, 23, 56, 63, 66, 77, 142
Contraceptive devices and drugs, 48, 49, 102, 103, 105, 107
Coordination of benefits, 132-140
Copayments, 27, 142
Cosmetic surgery, 65, 66, 125, 142
Cost-sharing, 27, 142
Covered providers, 18-21
Custodial care, 20, 80, 125, 142
Deductible, 27, 142
Definitions, 141-149
Dental care, 13, 31, 67, 112-117, 121, 127
Dept. of Defense (DoD) facilities (MTFs), 32
Diabetes Management Incentive Program, 119
Diabetic education, 19, 61, 81
Diagnostic services, 37-40, 79-80, 82, 83, 91, 92
Disputed claims process, Post-service claims, 130-131; Pre-service claims, 26
Donor expenses (transplants), 74, 75
Durable medical equipment, 57-58, 84, 87, 105, 125, 127, 142
Emergency, 21, 25, 35, 78, 89, 90-93, 112, 121, 140, 146, 147
Enrollment questions, 9-12, 18, 22
Exclusions, 125-126
Experimental or investigational, 68, 125, 130, 134, 143
Eyeglasses, 53-54
Flexible benefits option, 120
Foot care, 55
Formulary/Preferred drug list, 99
Foundation for the Accreditation of Cellular Therapy (FACT) accredited facility, 21, 72, 73
Freestanding ambulatory facilities, 20, 81-84
Generic drugs, 99, 101, 105, 107, 143
Generic Incentive Program, 101
Genetic screening/testing, 40, 41, 44, 48, 82
Health Tools, 118-120
Hearing aids and hearing services, 45, 53, 56
Home nursing care, 46, 51, 59, 87, 127, 136
Hospice care, 23, 86-88
Hospital, 8, 19, 21-23, 24-26, 31, 77-84, 94, 96, 121-122, 127, 135, 136, 139, 144
Immunizations, 41, 42, 44, 45, 84, 103, 126, 147
Independent laboratories, 19, 21, 39-40
Infertility services, 49-50, 102
Inpatient hospital benefits, 22, 24, 25, 26, 31, 78-80, 96, 136, 139, 144
Inpatient physician benefits, 21, 22, 37-38, 62, 63, 80, 95, 136
Insulin, 57, 102
Insulin pumps, 57
Laboratory and pathology services, 21, 39-40, 41-43, 45, 46, 79, 80, 81-84, 91, 92, 147
Magnetic Resonance Imaging (MRIs), CT scans, PET scans, 40, 82, 141
Mail Service Prescription Drug Program, 24, 98-101, 107, 122, 128, 129, 130, 147
Mammograms, 42
Maternity care, 19, 26, 46-48, 79, 82, 83, 84
Medicaid, 133
Medical foods, 58, 144
Medically necessary, 22-26, 125, 144
Medically underserved areas, 18, 144
Medicare, 23, 75, 85, 86, 101, 105, 107, 125, 132, 135-140
Member/Non-member facilities, 13-14, 30-32, 145-147
Mental health, 19, 46, 64, 94-97, 144, 145
Neurological testing, 39, 82
Never Events, 8, 125, 144
Newborn care, 37, 45, 47, 63
Nurse, 19, 46, 59, 76, 78, 85, 87, 96, 98, 118, 127
Nutritional counseling, 37, 42, 45, 64, 79
Obstetrical care, 19, 26, 46-48, 79, 82, 83, 84
Occupational therapy, 19, 52, 83, 87, 127
Office visits, 37, 41, 45, 95, 147
Oral statements, 5
Orthopedic devices, 55-56, 84
Osteopathic manipulative treatment, 60
Ostomy and catheter supplies, 58
Other covered health care professionals, 19
Out-of-pocket expenses, 27-32, 145-147
Outpatient facility benefits, 81-84
Overpayments, 32
Overseas claims, 31, 110, 121-122
Oxygen, 57, 58, 79, 81, 87, 125, 126
Pap tests, 42
Participating/Non-participating providers, 13-14, 18, 20, 21, 23, 24, 28-31, 145-147
Patient Safety and Quality Monitoring Program, 24, 100
Patients' Bill of Rights, 14
Pharmacotherapy, 37, 51, 95, 96
Physical examination, 41-42, 45, 84, 147
Physical therapy, 19, 37, 52, 83, 87, 127
Physician, 18
Plan allowance, 28-31, 145-147
Pre-admission testing, 79
Precertification, 22-24, 26, 32, 47, 62, 77, 79, 94, 96, 120, 121, 130, 131, 136, 147
Pre-existing conditions, 9, 12
Preferred Provider Organization (PPO), 13-14, 147
Prescription drugs, 24, 49, 87, 98-111, 122, 127, 128-129, 130, 135, 136, 137, 146, 147, 148
Preventive care, adult, 41-44, 84, 147
  children, 45, 47
Primary care provider, 18
Prior approval, 22-26, 46, 51, 62, 63, 64, 66, 67, 68, 70, 71, 73, 77, 86, 87, 98, 100, 120, 121, 128, 130, 131, 136, 147
Prostate cancer tests, 42
Prosthetic devices, 55-56, 63, 66, 79, 84
Psychologist, 19, 64, 94, 95, 96
Psychotherapy, 94-97
Radiation therapy, 23, 51, 81
Renal dialysis, 20, 51, 81
Retail Pharmacy Program, 13, 18, 24, 98-101, 103-105, 106, 122, 128, 130, 147
Room and board, 22, 38, 78, 80, 96
Second surgical opinion, 37
Skilled nursing facility care, 52, 58, 85, 105, 142
Smoking and tobacco cessation, 61, 102, 109, 118
Social worker, 19, 64, 94, 95, 96
Specialty Drug Pharmacy Program, 98-100, 105, 108, 122, 129, 130, 147, 148
Speech-generating devices, 57
Speech therapy, 19, 52, 83, 87, 127
Stem cell transplants, 20, 21, 23, 51, 68-75
Sterilization procedures, 48, 49, 63, 65
Subrogation, 133-134
Substance abuse, 19, 41, 94-97, 144, 145, 147
Surgery, 23, 24, 46, 62-67, 77, 81
  Assistant surgeon, 21, 36, 46, 62, 63
  Multiple procedures, 65
  Oral and maxillofacial, 67
  Outpatient, 23, 62-67, 77, 81
  Reconstructive, 66
Syringes, 102
Temporary Continuation of Coverage (TCC), 12, 138
Transplants, 20-21, 23, 51, 62, 68-75, 134, 148
TRICARE, 132
Urgent care centers, 91, 92
Urgent care claims, 25, 26, 131, 149
VA facilities, 32, 140
Vision services, 45, 53-54
Weight control, 23, 62, 63-64, 77, 118, 119, 123
Wheelchairs, 57, 89, 93
Workers' compensation, 131, 133, 134, 138
X-rays, 21, 39-40, 41, 82, 134, 147

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2014

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

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

Below, an asterisk (*) means the item is subject to the $350 per person ($700 per family) calendar year deductible. If you use a Non-PPO physician or other health care professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: Nothing for preventive care; 15%* of our allowance; $20 per office visit for primary care physicians and other health care professionals; $30 per office visit for specialists Non-PPO: 35%* of our allowance	37-38, 41-45
Services provided by a hospital:		
• Inpatient	PPO: $250 per admission Non-PPO: $350 per admission, plus 35% of our allowance	78-80
• Outpatient	PPO: 15%* of our allowance Non-PPO: 35%* of our allowance	81-84
Emergency benefits:		
• Accidental injury	PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: Any difference between the Plan allowance and billed amount for outpatient hospital and physician services within 72 hours; regular benefits thereafter Ambulance transport services: Nothing	90-93
• Medical emergency	PPO urgent care: $40 copayment; PPO and Non-PPO emergency room care: 15%* of our allowance; Regular benefits for physician and hospital care* provided in other than the emergency room/PPO urgent care center Ambulance transport services: $100 per day for ground ambulance (no deductible); $150 per day for air or sea ambulance (no deductible)	90, 92-93
Mental health and substance abuse treatment	PPO: Regular cost-sharing, such as $20 office visit copay; $250 per inpatient admission Non-PPO: Regular cost-sharing, such as 35%* of our allowance for office visits; $350 per inpatient admission, plus 35% of our allowance	94-97
Prescription drugs	Retail Pharmacy Program: • PPO: 20% of our allowance generic (15% if you have Medicare)/ 30% of our allowance preferred brand-name/45% of our allowance non-preferred brand-name • Non-PPO: 45% of our allowance (AWP) Mail Service Prescription Drug Program: • $15 generic ($10 if you have Medicare)/$80 preferred brand-name/ $105 non-preferred brand-name per prescription; up to a 90-day supply Specialty Drug Pharmacy Program: • See inside for details	98-111

Standard Option Summary – continued on next page

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2014 *(continued)*

Dental care	Scheduled allowances for diagnostic and preventive services, fillings, and extractions; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	67, 112-116
Special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor & Hospital Finder℠; Healthy Families; *WalkingWorks*® Wellness Program; travel benefit/services overseas; Care Management Programs; and Flexible benefits option		118-120
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	• Self Only: Nothing after $5,000 (PPO) or $7,000 (PPO/Non-PPO) per contract per year • Self and Family: Nothing after $6,000 (PPO) or $8,000 (PPO/Non-PPO) per contract per year ***Note:*** Some costs do not count toward this protection.	31-32

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2014

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

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

Basic Option does not provide benefits when you use Non-preferred providers. For a list of the exceptions to this requirement, see page 21. There is no deductible for Basic Option.

Basic Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: Nothing for preventive care; $25 per office visit for primary care physicians and other health care professionals; $35 per office visit for specialists Non-PPO: You pay all charges	37-38, 41-45
Services provided by a hospital:		
• Inpatient	PPO: $175 per day up to $875 per admission Non-PPO: You pay all charges	78-80
• Outpatient	PPO: $100 per day per facility Non-PPO: You pay all charges	81-84
Emergency benefits:		
• Accidental injury	PPO: $50 copayment for urgent care; $125 copayment for emergency room care Non-PPO: $125 copayment for emergency room care; you pay all charges for care in settings other than the emergency room Ambulance transport services: $100 per day for ground ambulance; $150 per day for air or sea ambulance	90-93
• Medical emergency	Same as for accidental injury	90, 92-93
Mental health and substance abuse treatment	PPO: Regular cost-sharing, such as $25 office visit copayment; $175 per day up to $875 per inpatient admission Non-PPO: You pay all charges	94-97
Prescription drugs	Retail Pharmacy Program: • PPO: $10 generic/$45 preferred brand-name per prescription/50% coinsurance ($55 minimum) for non-preferred brand-name drugs • Non-PPO: You pay all charges Specialty Drug Pharmacy Program: • See inside for details	98-111
Dental care	PPO: $25 copayment per evaluation (exam, cleaning, and X-rays); most services limited to 2 per year; sealants for children up to age 16; $25 copayment for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	67, 112-113, 117
Special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor & Hospital Finder℠; Healthy Families; *WalkingWorks*® Wellness Program; travel benefit/services overseas; Care Management Programs; and Flexible benefits option		118-120
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	• Self Only: Nothing after $5,500 (PPO) per contract per year • Self and Family: Nothing after $7,000 (PPO) per contract per year ***Note:*** Some costs do not count toward this protection.	31-32

2014 Rate Information

For 2014 health premium information, please see:
http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.