Blue Shield of California Access+ HMO®

http://www.blueshieldca.com/federal

Customer service (800)880-8086

blue of california

2015

A Health Maintenance Organization

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

Serving: Southern California

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

IMPORTANT
- Rates: Back Cover
- Changes for 2015: Page 15
- Summary of benefits: Page 77

Enrollment codes for this plan:

SI1 Self Only
SI2 Self and Family

Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-574

Important Notice from Blue Shield of California About Our Prescription Drug Coverage and Medicare

OPM has determined that the Blue Shield of California'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. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

Table of Contents 1
Introduction 4
Plain Language 4
Stop Health Care Fraud! 4
Preventing Medical Mistakes 5
FEHB Facts 8
- Coverage information 8
  - No pre-existing condition limitation 8
  - Minimum essential coverage 8
  - Minimum value standard 8
  - Where you can get information about enrolling in the FEHB Program 8
  - Types of coverage available for you and your family 8
  - Family member coverage 9
  - Children's Equity Act 9
  - When benefits and premiums start 10
  - When you retire 10
- When you lose benefits 10
  - When FEHB coverage ends 10
  - Upon divorce 11
  - Temporary Continuation of Coverage (TCC) 11
  - Converting to individual coverage 11
  - Health insurance marketplace 12

Section 1. How this plan works 13
- How we pay providers 13
- Your rights 13
- Your medical and claims records are confidential 13
- Service area 13

Section 2. Changes for 2015 15
- Changes to this Plan 15

Section 3. How you get care 16
- Identification Cards 16
- Where you get covered care 16
  - Plan providers 16
  - Plan facilities 16
- What you must do to get covered care 16
  - Primary care 16
  - Specialty care 16
  - Second Opinions 18
  - Urgent Care 18
  - Hospital Care 18
  - If you are hospitalized when your enrollment begins 18
- You need prior Plan approval for certain services 19
  - Inpatient hospital admission 19
  - Other services 19
- How to request precertification for an admission or get prior authorization for Other services 19
  - Non-urgent care claims 19

- Urgent care claims 20
- Concurrent care claims 20
- Emergency inpatient admission 20
- If your treatment needs to be extended 20

Circumstances beyond our control 20
If you disagree with our pre-service claim decision 20
- To reconsider a non-urgent care claim 21
- To reconsider an urgent care claim 21
- To file an appeal with OPM 21

Section 4. Your costs for covered services 22
Cost-sharing 22
Copayments 22
Coinsurance 22
Your catastrophic protection out-of-pocket maximum 22
Carry over 22
When Government facilities bill us 23
Section 5. Benefits - OVERVIEW 24
Section 5(a). Medical services and supplies provided by physicians and other health care professionals 26
Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals 37
Section 5(c). Services provided by a hospital or other facility, and ambulance services 44
Section 5(d). Emergency services/accidents 47
Section 5(e). Mental health and substance abuse benefits 49
Section 5(f). Prescription drug benefits 52
Section 5(g). Dental benefits 56
Section 5(h). Special features 57
Non-FEHB benefits available to Plan members 60
Section 6. General exclusions – services, drugs, and supplies we do not cover 61
Section 7. Filing a claim for covered services 62
Section 8. The disputed claims process 64
Section 9. Coordinating benefits with Medicare and other coverage 67
When you have other health coverage 67
- TRICARE and CHAMPVA 67
- Workers' Compensation 67
- Medicaid 67

When other Government agencies are responsible for your care 67
When others are responsible for injuries 68
When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage 68
Clinical Trials 68
What is Medicare? 68
- Should I enroll in Medicare? 69
- The Original Medicare Plan (Part A or Part B) 69
- Tell us about your Medicare coverage 70
- Medicare Advantage (Part C) 70
- Medicare prescription drug coverage (Part D) 70

Section 10. Definitions of terms we use in this brochure 72
Section 11. Other Federal Programs 74
The Federal Flexible Spending Account Program - FSAFEDS 74
The Federal Employees Dental and Vision Insurance Program - FEDVIP 75

The Federal Long Term Care Insurance Program - FLTCIP 75
Index....76
Summary of benefits for the Access+ HMO - 2015....77
2015 Rate Information for Blue Shield of California Access+ HMO....82

Introduction

This brochure describes the benefits of Blue Shield of California Access+ HMO under our contract (CS 2639) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. Customer service may be reached at (800) 880-8086 or through our website: www.blueshieldca.com/federal . The address for Blue Shield of California administrative offices is:

Blue Shield of California
Access+ HMO
50 Beale Street
San Francisco, CA 94105-1808

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2015, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2015, and changes are summarized on page 15. Rates are shown at the end of this brochure.

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

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

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means Blue Shield of California.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) 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 providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not billed for services that you did not receive.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- 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 (800) 880-8086 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

887-499-7295

OR go to www.opm.gov/oig

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she 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 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 your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

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

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

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

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

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

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

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

- **Minimum value standard**

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

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

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

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

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

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

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

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

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26.

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

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

- **Family member coverage**

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

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

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or

- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2015 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2014 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

  If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's 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). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

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

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

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

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

  In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at (800) 880-8086 or visit our website at **http://www.blueshieldca.com/federal**.

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

Section 1. How this plan works

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

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

When you receive services from Plan providers, you will not have to submit claim forms except for your annual eye exam. You only pay the copayments and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

How we pay providers

We contract with physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your co-payments or coinsurance.

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.

Corporate Form – Blue Shield of California is a not-for-profit corporation that was founded in 1939.

Fiscal Solvency – Blue Shield of California meets or exceeds California Department of Managed Health Care standards for fiscal solvency, confidentiality of medical records and transfer of medical records.

"Gag Clauses" – A "gag clause" is when a physician does not disclose all treatment options based on cost considerations. You have the right to have a clear understanding of the medical condition and any proposed appropriate necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before receiving treatment.

Medical Records – Access+ HMO members have the right, both under state law and Blue Shield of California policy, to review, summarize and copy their own medical records. Members can request and will receive amendments to their medical records as they are made.

State Licensing – Access+ HMO has been licensed by the State of California since 1978.

If you want more information about us, call us at (800) 880-8086, or write to Blue Shield of California Access+ HMO, P.O. Box 7168, San Francisco, CA 94120-7168. You may also contact us by fax at 916-350-8780 or visit our website at www.blueshieldca.com/federal.

Your medical and claims records are confidential

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

Service Area

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

Southern California full counties:

Fresno, Kings, Orange, Riverside, Santa Barbara, Tulare, and Ventura counties, California.

Partial counties: Kern, Los Angeles, San Bernardino and San Diego counties, California. The following ZIP codes are those **excluded** in these partial counties:

KERN:

93519, 93523, 93527, 93528, and 93554 to 93556

LOS ANGELES:

90704

SAN BERNARDINO:

92242, 92280 and 92363

SAN DIEGO:

91963

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will normally pay only for emergency or urgent care. We will not pay for any other health care service, except those that are specifically listed on page 60 under the heading "Medical Care for Vacations, Business Travel and College Students."

If you or a covered family member move outside the service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO like ours that has agreements with affiliates in other states. See page 60 for details about our HMO medical care available for vacations, business travel and college students coverage. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing agency or retirement office.

Section 2. Changes for 2015

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

Changes to this Plan

- Your share of the non-postal premium will increase for Self-Only and Self and Family (see page 80).
- Your out-of-pocket (OOP) cost for covered services are now $3,000 Self Only / $6,000 Family. Infertility services are excluded (see page 22).
- You are now eligible to receive a $50 gift card upon the completion of an online Well Being Assessment (see page 34).
- Prior Authorization for routine Mental Health Substance Abuse (MHSA) services defined as professional office visits in individual, family or group settings has been eliminated (see page 49).
- Prior Authorization is required for non-routine MHSA services (see page 49).
- Residential care for treatment of MHSA conditions is now covered at $200 per day up to three days (see page 50).
- You now pay 50% coinsurance, $50 minimum / $200 maximum per non-formulary retail plan pharmacy prescriptions (see page 53).
- You now pay 50% coinsurance, $100 minimum / $400 maximum per non-formulary mail service prescriptions (see page 53).

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (800) 880-8086. You may also request cards through our website www.blueshieldca.com

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay co-payments and/or coinsurance, and you will not have to file claims, except for your annual eye examination.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our website, www.blueshieldca.com/federal.

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. You must complete a Primary Care Physician Selection Form.

- **Primary care**

Your primary care physician can be a general practitioner, family practitioner, internist, pediatrician, or an OB/GYN. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician or IPA/ Medical Group leaves the Plan, call us at (800) 880-8086. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral.

The exceptions to this are:

1. for true medical emergencies;
2. when another physician is on call for your physician;
3. when you self-refer to an Access+ HMO participating specialist (not applicable to infertility, emergency and urgent care and allergy services; mental health and substance abuse Access+ HMO specialist care must be provided by a provider in Blue Shield's Mental Health Services Administrator (MHSA) network. (See page 48 for details.);
4. OB/GYN services provided by an obstetrician/gynecologist or family practitioner within the same IPA/Medical Group as your primary care physician.

In all other instances, referral to a specialist is done at the primary care physician's direction; if non-Plan specialists or consultants are required, the primary care physician will arrange appropriate referrals.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex or serious medical condition, your primary care physician will develop a treatment plan with you that allows an adequate number of direct access visits with that specialist. Your primary care physician will use our criteria when creating your treatment plan.
- Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. We will not pay for you to see a specialist who does not participate with our Plan, unless your primary care physician refers you to a non-Plan specialist for a second opinion.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan; or
  - reduce our service area and you enroll in another FEHB plan;

You may be able to continue seeing your specialist for up to 90 days or when clinically appropriate after you receive notice of the change. Contact us or, if we drop out of the program, contact your new Plan.

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

If you are a new Blue Shield of California Access+ HMO member and are currently receiving treatment for a qualifying medical condition from a provider who is not in our network, you may be eligible to complete treatment of your condition with the provider. Or, if you are an existing member and are currently receiving treatment for a qualifying medical condition from a provider who is leaving our network, you may be eligible to complete treatment of your condition with the provider. In order to receive more information about continuity of care and qualifying medical conditions and situations, please contact us at (800) 880-8086 and we will assist you.

Continuity of care is also available if you are currently receiving services for a serious mental health condition. To obtain further information, please contact our Mental Health Services Administrator (MHSA) directly by calling their Member Services at (877) 263-9952.

- **Second Opinions**

  If there is a question about your diagnosis or if additional information concerning your condition would be helpful in determining the most appropriate plan of treatment, your primary care physician will, upon request, refer you to another physician for a second medical opinion. If you are requesting a second opinion about care you received from your primary care physician, a physician within the same Medical Group/IPA as your primary care physician will provide the second opinion. If you are requesting a second opinion about care received from a specialist, any Plan specialist of the same equivalent specialty may provide the second opinion. We must authorize all second opinion consultations.

- **Urgent Care**

  We have made arrangements for an added benefit for you and your family for your urgent care needs when you or your family are temporarily traveling outside of your primary care physician's service area.

  When you are traveling outside of California, you can get urgent care services across the country and around the world through the BlueCard® Program. While traveling within the United States, you can locate a BlueCard provider any time by calling 1-800-810-BLUE (2583) or by going to www.blueshieldca.com/federal. If you are traveling outside of the United States you can call (804) 673-1177 collect 24 hours a day to locate BlueCard Worldwide® Network Provider.

  If you need urgent care while in your primary care physician's service area, you must first call your primary care physician. If your primary care physician (or your assigned medical group) has provided instructions to seek in-area urgent care at a local urgent care clinic you may do so without calling your primary care physician first.

  When you are traveling within California but you are outside of your primary care physician's service area, you should call Blue Shield Member Services at (800) 880-8086 for assistance in receiving Urgent Care through a Blue Shield of California Plan provider. You may also locate a Plan provider by visiting our web site at www.blueshieldca.com/federal. Remember that when you are within your primary care physician's service area, Urgent Care must be provided or authorized by your primary care physician just like all other non-emergency services of the Plan.

- **Hospital Care**

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

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

  We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our plan begins, call our member service department immediately at (800) 880-8086. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

  - you are discharged, not merely moved to an alternative care center;
  - the day your benefits from your former Plan run out; or
  - the 92nd day after you become a member of this Plan, whichever happens first.

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

You need prior Plan approval for certain services

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

- **Inpatient hospital admission**

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

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

Your primary care physician must obtain a preauthorization from us for: (1) selected drugs and drug dosages which require prior authorization for medical necessity, including most specialty drugs, (2) growth hormone therapy (GHT) (3) organ transplants (4) bone marrow transplants (5) cancer clinical trials (6) skilled nursing facility care and hospice care and (7) mental health and substance abuse services.

Refer to Section 5(b) for the preauthorization process for organ and bone marrow transplants.

Refer to Section 5(c) for preauthorization process for extended care/skilled nursing care facility and hospice care benefits.

Refer to Section 5(e) for preauthorization process for mental health and substance abuse benefits.

Refer to Section 5(f) for preauthorization process for drugs and drug dosages including home self-administered injectable drugs.

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

First, your physician, your hospital, you, or your representative, must call us at (800) 880-8086 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

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

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) to end of 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 (800) 880-8086. You may also call OPM's Health Insurance II at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at (800) 880-8086. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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

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

- **Emergency inpatient admission**

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

- **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.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

  Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

  1. Pre-certify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

  2. Ask you or your provider for more information.

  You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

  If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

  3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

  In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

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

Section 4. Your costs for covered services

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

Cost-sharing

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

Copayments

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

Example: When you see your primary care physician, you pay a copayment of $20 per office visit.

Coinsurance

Coinsurance is the percentage of our allowable fee that you must pay for your care.

Example: In our Plan, you pay 50% of our allowance for infertility services or durable medical equipment.

Your catastrophic protection out-of-pocket maximum

After your (co-payments and your coinsurance) total $3,000 for self only or $6,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay co-payments and/or coinsurance for these services:

1. infertility services

Be sure to keep accurate records of your co-payments and coinsurances since you are responsible for informing us when you reach the maximum. You must notify Blue Shield Member Services in writing when you feel that your catastrophic protection out-of-pocket maximum has been reached. At that time, you must submit complete and accurate records to us substantiating your copay and/or coinsurance expenditures. Receipts and/or statements must include: name of patient, date of service and amount paid.

Send information to:

Blue Shield of California
Access+ HMO Member Services
P.O. Box 272550
Chico, CA 95927

or

Fax: to 916-650-8780

For assistance call us at (800) 880-8086.

Carryover

If you changed to this Plan during open season from a Plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that Plan's catastrophic protection benefit during the prior year will be covered by your old Plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old Plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old Plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old Plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

When Government facilities bill us

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

Section 5. Benefits - OVERVIEW

See page 15 for how our benefits changed this year and page 77 for a benefits summary.

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us (800) 880-8086 or at our Web site at www.blueshieldca.com/federal.

Section 5. Benefits - OVERVIEW 24
Section 5(a). Medical services and supplies provided by physicians and other health care professionals 26
- Diagnostic and treatment services 26
- Lab, X-ray and other diagnostic tests 26
- Preventive care, adult 27
- Preventive care, children 28
- Maternity care 28
- Family planning 29
- Infertility services 29
- Allergy care 30
- Treatment therapies 30
- Physical and occupational therapies 30
- Speech therapy 31
- Hearing services (testing, treatment, and supplies) 31
- Vision services (testing, treatment, and supplies) 31
- Foot care 31
- Orthopedic and prosthetic devices 32
- Durable medical equipment (DME) 32
- Home health services 33
- Chiropractic/Alternative treatments 34
- Educational classes and programs 34
- Clinical trials 36

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals 37
- Surgical procedures 37
- Reconstructive surgery 38
- Oral and maxillofacial surgery 39
- Organ/tissue transplants 39
- Anesthesia 43

Section 5(c). Services provided by a hospital or other facility, and ambulance services 44
- Inpatient hospital 44
- Outpatient hospital or ambulatory surgical center 45
- Extended care benefits/Skilled nursing care facility benefits 45
- Hospice care 45
- Ambulance 46

Section 5(d). Emergency services/accidents 47
Section 5(e). Mental health and substance abuse benefits 49
- Routine outpatient mental health and substance abuse benefits 49
- Not covered 50

Section 5(f). Prescription drug benefits 52
- Covered medications and supplies 53

Section 5(g). Dental benefits....56
Accidental injury benefit....56
Section 5(h). Special features....57
Flexible benefits option....55
High Risk Pregnancies....55
Self-referral to specialty services....55
NurseHelp 24/7....56
Health support programs....57
Summary of benefits for the Access+ HMO - 2015....77

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.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • During a hospital stay • In a skilled nursing facility • Vaccines for pediatric and adult immunizations • Inpatient non-dental treatment of temporomandibular joint (TMJ) syndrome	Nothing
• Office visits, including routine newborn circumcision performed within 31 days of birth unrelated to illness or injury and asthma self-management training. • Office medical consultations • Second opinions	$20 per office visit
• Home visit by physician	$25 per visit
• Self-referral to a Plan specialist under Access+ HMO option	$30 per office visit
• In an urgent care center	$20 per visit
• Home visit by nurse or health aide	$5 per visit
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Pathology • X-rays • Ultrasound • Electrocardiogram and EEG • Genetic testing & diagnostic procedures for certain conditions	Nothing
Tests, such as: • CT Scans • PET Scans • MRI • Nuclear Scans	$200 per test

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

Benefit Description	You pay
Lab, X-ray and other diagnostic tests (cont.)	**High Option**
• Angiograms (including heart catheterizations) • Arthrograms • Myelograms • Ultrasounds not associated with maternity care	$200 per test
Preventive care, adult	**High Option**
Routine screenings, such as: • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening - every five years starting at age 50 - Colonoscopy every ten years starting at age 50 • Osteoporosis Screening - Routine screening for women aged 65 and older - Evaluation of risk factors for women under age 65. Women at risk may need a screening test.	Nothing
Well woman care including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual Counseling for sexually transmitted infections. • Annual Counseling and screening for human immune-deficiency virus. • Contraceptive methods and counseling. • Screening and counseling for interpersonal and domestic violence.	Nothing
Routine mammogram - covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every year • At age 65 and older, one every two years	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing
Adult routine immunizations as recommended by the Center for Disease Control (CDC)	Nothing
Note: A complete list of preventive care services recommended under the U.S. Preventive Service Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm and HHS at www.healthcare.gov/prevention.	
Biometric screenings Biometric screenings gather key health indicators such as total cholesterol, blood pressure, BMI, Triglycerides, and fasting glucose. Your PCP will record your values on the physician fax biometric screening form and submit the form via fax that includes both you and your doctor's signature. The form for the screening can be downloaded at www.blueshieldca.com/federal You, your spouse, and dependents are eligible to participate.	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
As an incentive, once you complete your biometric screening, you will receive a $25 gift card. If you complete your online Well-Being Assessment, you will receive an additional $50 incentive. Please refer to the Well-Being Assessment benefit description for further information.	Nothing
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Lyme disease immunizations.* • *Travel immunizations.*	*All charges*
Preventive care, children	**High Option**
Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
Well-child care charges for routine examinations, immunizations and care (through age 22) Examinations, such as: • Eye exams through age 17 to determine the need for vision correction, which include: • Hearing exams through age 17 to determine the need for hearing correction, which include: • Examinations done on the day of immunizations (up to age 22) Note: A complete list of preventive care services recommended under the U.S. Preventive Service Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm and HHS at www.healthcare.gov/prevention.	Nothing
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Delivery • Postnatal care	Nothing
Breastfeeding support, supplies and counseling for each birth • Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment. • Breast pump rental or purchase is only covered if obtained from a designated Plan provider in accordance with Blue Shield Medical Policy. For further information call Member Services at (800) 880-8086 or go to www.blueshieldca.com	Nothing
Note: Here are some things to keep in mind: • You do not need to pre-certify your normal delivery for other circumstances, such as extended stays for you or your baby.	

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**High Option**
• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	
Family planning	**High Option**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	Nothing
Voluntary Sterilization (See Surgical procedures Section 5 (b)) • Vasectomy • Tubal ligation	 $75 Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility such as: • Artificial insemination (up to six cycles per pregnancy): - Intravaginal insemination (IVI) - Intra-cervical insemination (ICI) - Intrauterine insemination (IUI) • Covered injectable fertility drugs Note: We cover Injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	50% of plan allowance
Oral fertility drugs (See *Prescription Drug Benefits*)	Regular cost sharing
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)* • *Services, supplies and drugs related to excluded ART procedures*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High Option**
• *Cost of donor sperm, eggs and frozen embryos and their collection and storage*	*All charges*
Allergy care	**High Option**
• Allergy serum	Nothing
• Testing and treatment • Allergy injection	$20 per office visit
• Customized antigens	50% of plan allowance
Not covered: • *Provocative food testing* and *sublingual allergy desensitization*	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 39. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page 19.	$20 per office visit
Physical and occupational therapies	**High Option**
These are covered benefits when determined by us to be medically necessary and it is demonstrated that the member's condition will significantly improve as a result of the rehabilitative and/or habilitative services. • Qualified physical therapists • Occupational therapists. Note: Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.	$20 per office visit
Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided at a Plan facility, if medically necessary with the appropriate treatment plan.	$20 per visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*

Benefit Description	You pay
Speech therapy	**High Option**
Speech therapy by a qualified speech therapist is covered when it is determined by us to be medically necessary and it is demonstrated that the member's condition will significantly improve as a result of the rehabilitative and/or habilitative services.	$20 per office visit
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	$20 per office visit
Audiological evaluation to measure hearing loss and to determine the most appropriate make and model of hearing aid.	$20 per office visit
Not covered: • *All other hearing testing* • *Batteries and other equipment after the initial purchase of your hearing aid.* • *Charges for a hearing aid that exceeds the requirements prescribed for the correction of your hearing loss.* • *Replacement parts and repair after one year* • *Replacement of hearing aid more than once in any period of 24 months.*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
Contact lenses, if medically necessary to treat eye conditions such as keratoconus, keratitis sicca and aphakia or when required as a result of cataract surgery when no intraocular lens has been implanted, are covered.	$20 per office visit
Annual eye refraction; in addition to the medical and surgical benefits provided for diagnosis and treatment of disease of the eye, an annual eye refraction (to provide a written lens prescription) may be obtained from Vision Plan Administration (VPA) providers. VPA provider directories can be accessed through www.blueshieldca.com/federal or by calling Blue Shield Member Service at (800) 880-8086. Note: See *Preventive care, children* for eye screenings for children.	$20 per office visit
Not covered: • *Eyeglasses or contact lenses (See page 60 for details about eyewear discounts)* • *Eye exercises and orthoptics* • *Radial keratotomy, refractive keratoplasty and other refractive surgery* • *Video assisted visual aids or video magnification equipment*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$20 per office visit
Not covered: Routine foot care	*All charges*

Benefit Description	You pay
Orthopedic and prosthetic devices	**High Option**
• Surgically implanted breast implant following mastectomy • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Blom-Singer and artificial larynx prostheses following a laryngectomy • Stump hose	Nothing
• Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. - Inpatient Hospital - Outpatient Hospital Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	 Nothing for the device; inpatient hospital copay applies Nothing for the device; outpatient copay applies
• Orthopedic devices (and their repair) such as braces; or foot orthoses that are custom-made and demonstrated to have therapeutic effect. • Prosthetic devices (and their repair) such as artificial limbs and contact lenses necessary to treat certain medical eye conditions. Contact us for details.	50% of plan allowance
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Includes supplies such as the initial battery, cords and other hearing aid equipment. Includes visits for fitting, counseling, adjustments, and repairs for one year after you receive your hearing aid(s). We will pay up to a maximum of $1,000 per member every 24 months for both ears for the hearing aid instrument, supplies and equipment.	Charges above the maximum payment of $1,000 per member every 24 months
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads, and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Penile prostheses* • *Backup or alternate items*	*All charges*
Durable medical equipment (DME)	**High Option**
Purchase or rental up to the purchase price, including repair and adjustment, of durable medical equipment prescribed by your Plan physician. Replacement of DME is covered only when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item. Under this benefit, we cover: • Oxygen • Dialysis equipment • Colostomy/ostomy supplies • Hospital beds	50% of plan allowance with no annual maximum

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**High Option**
• Wheelchairs • Crutches • Walkers • Canes • Traction equipment • Blood glucose monitors • Apnea monitor for management of newborns • Nebulizers, including face masks and tubing, and peak flow monitors for the management and treatment of asthma. See section 5(f) Prescription Drug Benefits for asthma inhalers and inhaler spacers. Note: Call us at (800) 880-8086 as soon as your Plan physician prescribes this equipment. We have contracted with health care providers to rent or sell you durable medical equipment at discounted rates and we will tell you more about this service when you call.	50% of plan allowance with no annual maximum
Not covered: • *Exercise equipment* • *Disposable medical supplies for home use, except colostomy/ostomy supplies* • *Speech/language assistance devices except as listed under prosthetic devices* • *Self-monitoring equipment and home testing devices, except as listed in the covered section* • *Wigs* • *Generators* • *Backup or alternate items*	*All charges*
Home health services	**High Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R. N.), Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (ST), Respiratory Therapist (RT), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, intravenous therapy and medications, except for home self-administered injectable drugs Note: See Section 5(f) Prescription Drug Benefits for home self-injectable therapy obtained from a Plan pharmacy.	$5 per visit
• Home visit by physician	$25 per visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Drugs or supplies that do not require a physician's prescription, even if a physician prescribes them, unless they are listed as covered*	*All charges*

Benefit Description	You pay
Chiropractic/Alternative treatments	**High Option**
Chiropractic services (up to 20 medically necessary visits per year); members may self-refer to American Specialty Health Plans of California, Inc. (ASH Plans) Providers by calling 800-678-9133 or visiting our website for participating practitioners	$10 per office visit
Each member is allowed a pre-authorized appliance benefit of up to $50 per year. Appliance benefits that are pre-authorized such as: • Elbow supports • Back supports (Thoracic) • Cervical collars	All charges above $50 per year
Not covered: • *All charges after the 20 visit annual maximum* • *Naturopathic services* • *Hypnotherapy* • *Services for or related to acupuncture* *Note: See page 60 for Non-FEHB benefits available to plan members. Discount programs are available through the mylifepath Alternative Health Services Discount Program for acupuncture, chiropractic and massage therapy.*	*All charges*
Educational classes and programs	**High Option**
Coverage is provided for: • Preventive health reminders and educational publications available online at www.blueshieldca.com/federal	Nothing
Well-Being Assessment and online wellness tools The Well-Being Assessment is an online tool that helps members discover potential health risks and recommends positive steps to control those risks. There are multiple wellness online tools and content available for members to learn more about becoming healthy and assist with making small behavior changes and help members create healthy changes. You can access the Well-Being Assessment by logging into your account at www.blueshieldca.com As an incentive, once you complete you online Well-Being Assessment, you will receive a $50 gift card. If you complete a biometric screening with your personal care physician, you will receive an additional $25 incentive. Please refer to the Biometric Screening benefit description for further information.	Nothing
Quit for Life: A Tobacco Cessation Program provided by Free and Clear© and the American Cancer Society®, including: • Up to five outbound coaching calls from a Quit Coach • Unlimited phone access to a Quit Coach during hours of operation, which are 5 a.m. to 12 a.m. PST, every day except July 4th, Thanksgiving Day and Christmas Day • Unlimited access to Web Coach®, Free & Clear's interactive online community featuring e-learning tools, social support, and information about quitting • A Quit Guide with helpful and stage-appropriate guidance around quitting smoking, mailed to participating members	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
• An 8-week course of nicotine replacement therapy gum or patches, mailed directly to members • Expert decision support and recommendations for FDA-approved prescription pharmocotherapy pertaining to tobacco cessation • Personalized motivational e-mails to members • Unlimited access to the Tobacco Tool Kit, an online collection of program support and promotional materials featuring guidelines, strategies, and tools for maximizing participation in the program Note: You can re-enroll in the program six months after your initial enrollment. *See also: Section 5(f) - Prescription drug benefits, page 52.*	Nothing No copay for generic, brand name and over-the-counter tobacco cessation medications when prescribed by a physician. if you request a brand name prescription medication over an available generic version, then you will be responsible for the generic copayment plus the difference in price of brand name and generic drugs.
Prenatal Program – offering a wide range of educational materials to support health during pregnancy (preparation and staying healthy) and post-delivery (postpartum care, caring for an infant and toddler), including: • *Prenatal Guide* filled with information on fitness, nutrition, emotions, body changes, doctor visits, prenatal tests, postpartum depression, and a home safety checklist to prepare for the baby's arrival • Text4Baby^{sm} enrollment information • Personal pregnancy calendar • First-aid chart • Vaccination information • Information about postnatal care For more information, or to enroll, visit www.blueshieldca.com/hw	Nothing
Programs for members 65 and older Preventive care visits to discuss exercise or physical therapy and vitamin D supplementation to prevent falls is a covered service for patients who meet all of the following criteria (OTC medications are not a covered benefit):community-dwelling adults (excluding institutionalized, facility-based adults, such as those in Skilled Nursing Facilities) aged 65 years or older at increased risk for fall.	Nothing
Behavioral counseling to prevent skin cancer for children and young adults age 10 - 24 Behavioral counseling about minimizing exposure to ultraviolet radiation to reduce risk for skin cancer is a covered service for patients with fair skin who meet any of the following criteria: Children age 10 and older to young adults to age 24. These services are considered inclusive in the preventive care visit, and therefore not separately reimbursable	Nothing

Benefit Description	You pay
Clinical trials	**High Option**
Benefits are provided for routine patient care for a member whose personal physician has obtained prior authorization from the Plan and who has been accepted into an approved clinical trial provided that: 1. The clinical trial has a therapeutic intent and the member's treating physician determines that participation in the clinical trial has a meaningful potential to benefit the member with a therapeutic intent; and 2. The member's treating physician recommends participation in the clinical trial; and 3. The hospital and/or physician conducting the clinical trial is a Plan provider, unless the protocol for the trial is not available through a Plan provider. Charges for routine patient care will be paid on the same basis and at the same benefit levels as any other similar covered service or supply. Routine patient care consists of those services that would otherwise be covered by the Plan if those services were not provided in connection with an approved clinical trial, but does **not** include: 1. Drugs or devices that have not been approved by the federal Food and Drug Administration (FDA); 2. Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses; 3. Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient; 4. Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the Plan; 5. Services customarily provided by the research sponsor free of charge for any enrollee in the trial. An approved clinical trial is limited to a trial that is: 1. Approved by one of the following: a. one of the National Institutes of Health; b. the U.S. Food and Drug Administration, in the form of an investigational new drug application; c. the United States Department of Defense; d. the United States Veterans' Administration; or e. Involves a drug that is exempt under federal regulations from a new drug application.	Covered as any other similar service or supply

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility charge (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus, when medically necessary • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Treatment of burns • Circumcisions performed during newborn's post delivery stay in hospital • Surgical treatment of morbid obesity (bariatric surgery) – for members who meet Blue Shield Medical Policy and clinical criteria for covered procedures and services that have been approved by their primary care physicians. Covered procedures: • Roux-en-Y Gastric Bypass • Vertical Banded Gastroplasty • Duodenal Switch, Distal Gastric Bypass limited to Body Mass Index (BMI) of 50 or greater • Laparoscopic Adjustable Gastric Band Clinical criteria includes, but is not limited to: • The patient has a BMI greater than 40 or between 35 and 40 with a co-morbid condition such as a life-threatening cardiopulmonary condition, severe or uncontrolled diabetes, or sleep apnea.	$200 per day up to 3 days $20 per office visit when service provided in the office

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
• It is the first surgery for obesity. • There is documentation showing a comprehensive history and physical evaluation, done within the last three months • The patient has actively participated in physician-directed non-surgical methods of weight reduction • There is documentation for a recent psychological evaluation For more information regarding clinical criteria for covered procedures, please contact us at (800) 880-8086 and we will assist you.	$200 per day up to 3 days $20 per office visit when service provided in the office
Insertion of internal prosthetic devices. See Section 5(a) Orthopedic and prosthetic devices for device coverage information.	$10 per procedure
Outpatient hospital surgery and supplies including routine newborn circumcision performed within 31 days of birth unrelated to illness or injury	$250 per surgery
Voluntary Sterilization • Vasectomy • Tubal ligation	 $75 Nothing
Not covered: • *Surgical treatment of morbid obesity (bariatric surgery) procedures not listed as covered and repeat surgery due to behavioral failure* • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot*	*All Charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities, cleft lip, cleft palate, birth marks, webbed fingers, and webbed toes • Surgery to correct cleft lip and cleft palate include dental or orthodontic services that are an integral part of the reconstructive surgery.	Inpatient hospital copay applies Outpatient hospital copay applies
• All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Inpatient hospital copay applies Outpatient hospital copay applies
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All Charges*

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**High Option**
• *Surgeries related to sex transformation* • *Reimplantation of breast implants originally provided for cosmetic surgery*	*All Charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Surgical and anthroscopic treatment of TMJ is covered if prior history shows conservative medical treatment has failed. Splint therapy and physical therapy is covered, see Section 5(a) • Other surgical procedures that do not involve the teeth or their supporting structures	Inpatient hospital copay applies Outpatient hospital copay applies
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow Failure and Related Disorders (i.e. Franconi's, PNH, pure red cell aplasia) - Mucolipidosis (e.g. Gaucher's disease, metchromatic leukodystrophy, adrenoleukodystrophy) - Mucoplysaccharidosis (e.g. Hurler's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g. Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer (clinical trials only) - Ependymoblastoma - Epithelia ovarian cancer - Ewing's sarcoma - Multiple myeloma - Medullablastoma - Pineoblastoma - Neuroblastoma - Testicular, mediastinal, Retroperitoneal, and ovarian germ cell tumors	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
Mini-transplants performed in a clinical trial setting (non-myeloblative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to a medical necessity review by the Plan. Refer to *Services requiring our prior approval* in Section 3 for prior authorization procedures. • Allogenic transplants for - Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloprofliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e. Franconi's, PNH, Pure Red Cell Aplasia) - Myelodyplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e. myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	Nothing
These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogenic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflamatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma	

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Multiple sclerosis - Sickle cell anemia • Mini-transplants (non-myeloblative allogenic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders (MPDs) - Renal cell carcinoma - Sickle cell anemia • Autologous Transplants for - Advanced Childhood Kidney cancers - Advanced Ewing sarcoma - Advanced Hodkin's Lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphoma - Breat Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin Lymphoma) - Multiple sclerosis National Transplant Program (NTP) - Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • *Travel expenses unless authorized by us*	*All Charges*

Benefit Description	You pay
Anesthesia	**High Option**
Professional services provided in: • Hospital (inpatient) • Skilled Nursing Facility	Nothing
Professional services provided in: • Hospital outpatient department • Ambulatory surgical center • Office	Outpatient copayment applies

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are covered in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as: • Semiprivate or intensive care accommodations • General nursing care • Meals and special diets when medically necessary • Special duty nursing when medically necessary • Private rooms when medically necessary NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$200 per day up to 3 days
Other hospital services and supplies, such as: • Operating, recovery, delivery room, newborn nursery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and x-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home • Radiation therapy, chemotherapy, and renal dialysis	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, convalescent care facilities and schools*	*All Charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
• *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All Charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, x-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover dental procedures for non-accidental injury to natural teeth. See page 48.	$250 per treatment or surgery including necessary supplies
Not covered: Blood and blood derivatives if replaced by the member	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**
We provide benefits up to 100 days each calendar year when full time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by your Plan physician and approved by us. Admissions to a sub-acute care setting require prior approval and are limited to 100 days each calendar year. All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan physician	Nothing
Not covered: Custodial care, rest cures, domiciliary or convalescent care and comfort items such as a telephone and television. All charges after the 100 day annual maximum.	*All Charges*
Hospice care	**High Option**
We cover the following services through a participating hospice agency when the member has a terminal illness with a prognosis of life of one year or less as determined by the member's Plan provider's certification. Admission to the hospice program must be prior approved by Blue Shield and the delegated IPA/MG. If the member lives longer than one year, hospice coverage can continue for a period of care if the Plan provider recertifies that the member still needs and remains eligible for hospice care. Upon recertification a member can receive care for two 90-day periods followed by an unlimited number of 60-day periods. Members can continue to receive covered services that are not related to the palliation and management of the terminal illness from the appropriate Plan provider. Subject to appropriate Plan copays for the type of covered services. Hospice coverage includes:	Nothing in a hospice facility Nothing for home physician visit Nothing for visit of other health care providers

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	**High Option**
• Pre-hospice consultative visit regarding pain and symptom management, hospice and other care options including care planning (You do not have to be enrolled in the hospice program to receive this benefit). • Interdisciplinary team care to develop and maintain an appropriate plan of care. • Nursing care services are covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain a member at home. Hospitalization is covered when the interdisciplinary team makes the determination that skilled nursing care is required at a level that can't be provided in the home. • Skilled nursing services, certified health aide services and homemaker services under the supervision of a qualified registered nurse. • Drugs and medicine, medical equipment and supplies that are reasonable and necessary for the palliation and management of terminal illness and related conditions. • Physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills. • Social services/counseling services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, will also be provided when needed. • Short-term inpatient care necessary to relieve family members or other persons caring for the member. Such respite care is limited to an occasional basis and to no more than five consecutive days at a time. • Volunteer services. • Bereavement services.	Nothing in a hospice facility Nothing for home physician visit Nothing for visit of other health care providers
Not covered: Independent nursing, homemaker services	*All Charges*
Ambulance	**High Option**
Local professional ambulance service when ordered or authorized by a Plan physician.	Nothing

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.
- We have no calendar year deductible.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- No prior authorization is required.

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, including active labor, and a psychiatric medical condition. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area

If you are in an emergency situation, please call your local emergency system (e.g., the 911 telephone system), where available, or go to the nearest hospital emergency room. Please call your primary care physician as soon as it is reasonably possible. Be sure to tell the emergency room personnel that you are a Plan member so they can notify us. You or a family member should notify us. It is your responsibility to ensure that we have been notified.

If you need to be hospitalized, we must be notified immediately following your admission, unless it was not reasonably possible to notify us within that time. If you are hospitalized in a non-Plan facility and a Plan physician believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition. Any follow-up care recommended by non-Plan providers must be approved by us or provided by Plan providers.

We pay reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers. If the emergency results in admission to a hospital, any applicable copayment is waived.

Emergencies outside our service area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, we must be notified immediately following your admissions, unless it was not reasonably possible to notify us within that time. If you are hospitalized in a non-Plan facility and a Plan physician believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers.

Note: If the emergency results in admission to a hospital, the copayment is waived.

Benefit Description	You pay
Emergency within our service area	**High Option**
Emergency care at a doctor's office	$20 per visit
• Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: If the emergency results in admission to a hospital, the copayment is waived.	$20 per visit $100 per visit
Not covered: Elective care or non-emergency care	*All Charges*
Emergency outside our service area	**High Option**
Emergency care at a doctor's office	$20 per visit
• Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: If the emergency results in admission to a hospital, the copayment is waived.	$20 per visit $100 per visit
Not covered:Elective care or non-emergency care	*All Charges*
Ambulance	**High Option**
Professional ambulance service when medically appropriate. Note: See Section 5(c) for non-emergency service.	Nothing
Not covered: Taxi, wheelchair van, other non-ambulance assisted transportation	*All Charges*

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

Important things you should keep in mind about these benefits:

- Please remember that benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR NON-ROUTINE OUTPATIENT AND INPATIENT SERVICES**. See the instructions after the benefits description below.

Benefit Description	You pay
Routine outpatient mental health and substance abuse benefits	**High Option**
All diagnostic and treatment services recommended by Plan providers and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Benefits are provided for professional (Physician) office visits for the diagnosis and treatment of Mental Health and Substance Abuse Conditions in the individual, family or group setting.	$20 per visit
Non-routine outpatient mental health and substance abuse benefits	**High Option**
Benefits are provided for outpatient facility and professional services for the diagnosis and treatment of Mental Health and Substance Abuse Conditions. These services may also be provided in the office, home or other non-institutional setting. Non-routine outpatient mental health and substance abuse services must be prior authorized by the MHSA. Non-routine outpatient mental health and substance abuse services include, but may not be limited to, the following: **Intensive Outpatient Program (IOP)** - an outpatient mental health or substance abuse treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.	Nothing
Office-based opioid treatment – outpatient opioid detoxification and/or maintenance therapy.	Nothing
Psychological Testing - testing to diagnose a Mental Health Condition when referred by an MHSA Participating Provider.	Nothing
Transcranial Magnetic Stimulation - a non-invasive method of delivering electrical stimulation to the brain for the treatment of severe depression**.**	Nothing
Electroconvulsive Therapy (ECT) – the passing of a small electric current through the brain to induce a seizure, used in the treatment of severe mental health conditions.	Nothing

Non-routine outpatient mental health and substance abuse benefits - continued on next page

Benefit Description	You pay
Non-routine outpatient mental health and substance abuse benefits (cont.)	**High Option**
Partial Hospitalization Program (PHP) (also referred to as day care) – an outpatient treatment program that may be freestanding or Hospital-based and provides services at least five hours per day, four days per week. Members may be admitted directly to this level of care, or transferred from inpatient care following acute stabilization. *An episode of care is the date from which you are admitted to the partial hospitalization program in a facility to the date you are discharged or voluntarily leave treatment. Any services received between these two dates constitute an episode of care. If you need to be readmitted at a later date, this would constitute another episode of care.	Nothing
Applied Behavior Analysis (ABA) Therapy / Behavioral Health Treatment (BHT) – Professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism. ABA/BHT is covered when prescribed by a Physician or licensed psychologist who is a Plan Provider and the treatment is provided under a treatment plan prescribed by an MHSA Participating Provider. ABA/BHT must be prior authorized by the MHSA and obtained from MHSA Participating Providers. ABA/BHT used for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment is not covered.	Nothing
Inpatient services	**High Option**
Benefits are provided for inpatient hospital and professional services in connection with acute hospitalization and residential care admission for treatment of Mental Health Conditions or Substance Abuse Conditions. Inpatient services for the treatment of mental health and substance abuse must be prior authorized by the MHSA.	$200 per day up to 3 days
Not covered	**High Option**
Not covered: Services for which prior authorization is required but not obtained.	*All charges*

Preauthorization	Prior authorization is required for all non-emergency mental health and substance abuse hospital admissions including acute inpatient care and residental care. Non-routine outpatient mental health services, including, but not limited to, Behavioral Health Treatment, Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Electroconvulsive Therapy (ECT), Psychological Testing and Transcranial Magnetic Stimulation (TMS) must also be prior authorized by the MHSA. To be eligible to receive these benefits you must follow your approved treatment plan and all the following authorization processes: To obtain an authorization, call Blue Shield's Mental Health Services Administrator (MHSA) at 877-263-9952. You should continue to identify yourself as a Blue Shield member and use your Blue Shield identification card and identification numbers when contacting the MHSA or its participating providers. Your health care provider should contact Blue Shield's Mental Health Services Administrator (MHSA) at 877-263-9952 to obtain information about joining the MHSA network, obtaining an authorization for your treatment, or to speak with a member of MHSA's clinical staff about issues related to this benefit or your care.

	If you would like a copy of a provider directory, you can contact the Blue Shield Member Services Department at (800) 880-8086. OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You Pay
Out-of-Network mental health and substance abuse benefits	**High Option**
Not covered out-of-network care	*All Charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, including most specialty drugs, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- We have no calendar year deductible.
- Be sure to read Section 4, Your *costs for covered services*, for valuable information about how cost-sharing works. Also read section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should know about your prescription drug benefit. These include:

- **Who can write your prescription?** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where can you obtain your prescriptions?** You must fill the prescription at a network retail pharmacy, or network mail service pharmacy for a maintenance medication; however, specialty drugs must be filled by a Network Specialty pharmacy. To select a Network Specialty pharmacy you may go to www.blueshieldca.com/federal or call toll-free Member Services at (800) 880-8086.
- Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancer, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Infused or Intravenous (IV) medications are not included as Specialty Drugs. These Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy & Therapeutics Committee, be obtained from a Blue Shield Network Specialty Pharmacy and may require prior authorization for Medical Necessity by Blue Shield. Prescriptions for specialty medications are available for up to a 30 day supply per fill only.
- **We use a formulary.** Prescription drug coverage is based on the use of the prescription drug formulary, a copy of which is available to you. Medications are selected for inclusion in Blue Shield's Outpatient Prescription Drug Formulary based on safety, efficacy, and FDA bio-equivalency data. The Blue Shield Pharmacy and Therapeutics Committee reviews new drugs and clinical data four times a year. Members may call Blue Shield Member Services at 800-880-8086 to find out if a specific drug is included in the formulary. Formulary information is available on Blue Shield's website at www.blueshieldca.com/federal. Non-formulary drugs are always covered at the non-formulary copayment, unless excluded from the prescription drug benefit.

  Selected drugs and drug dosages and most specialty drugs require prior authorization for medical necessity. You should not become directly involved with us for this pre-authorization process. Your physician is responsible for obtaining prior authorization and documenting medical necessity. If all necessary documentation is available from your physician, prior authorization approval or denial will be provided to your physician within five working days of the request.
- **In lieu of brand name drugs, generic drugs will be dispensed** when substitution is permissible by the physician. If you request a brand name drug when a generic drug is available, you pay the difference between the cost of the brand name drug and its equivalent generic drug, plus the generic copayment.

- **Prescription Days Supply Covered:** A retail Plan pharmacy may dispense up to a 30-day supply for the appropriate copayment. Some prescriptions have specific limits on how much of the medication you can get with each prescription or refill. This is to ensure that you receive the recommended and proper dose and length of drug therapy for your condition. Quantity limits are based on medical necessity and appropriateness of therapy as determined by Blue Shield's Pharmacy and Therapeutics Committee. You will pay the appropriate copayment per prescription for out-of-state emergencies. Only maintenance drugs are available for up to a 90-day supply at the appropriate copayment per prescription through the Plan mail service pharmacy. Maintenance drugs are drugs commonly prescribed for six months or longer to treat a chronic condition and are administered continuously rather than intermittently. Call Member Services at (800) 880-8086 to receive a packet for ordering prescriptions through the mail.

  If a member requires an interim supply of medication due to an active military duty assignment or if there is a national emergency, up to a 90-day supply will be approved for covered medications. Contact Member Services at (800) 880-8086 for immediate assistance.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the brand name is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and brand name drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you -- and us -- less than a brand name prescription.
- •**Step Therapy** Step therapy is a component of prior authorization. This program requires that members must try one or more "pre-requisite" drug(s) first before the "step-therapy" product will be covered. If a "prerequisite" drug is not effective in treating the member's condition or if it is documented that the member has previously attempted the use of one or more step therapy prerequisite medications, then the member's physician may apply for an exception.

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a retail Plan pharmacy or through our mail service pharmacy: • Diabetic supplies limited to disposable insulin syringes, needles, pen delivery systems for the administration of insulin as determined by Blue Shield to be medically necessary and glucose testing tablets and strips • Formulary and non-formulary drugs for sexual dysfunction or sexual inadequacies will be covered when the dysfunction is caused by medically documented organic disease. Prior Plan approval is required and the maximum dosage dispensed will be limited by the protocols established by us. Certain drugs for these conditions are not available through the Mail Service option. • Formulary and non-formulary drugs and medicines that by federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Insulin • Disposable needles and syringes for the administration of covered medications • Inhalers and inhaler spacers for the management and treatment of asthma. • Formulary and non-formulary oral contraceptive drugs and diaphragms.	$10 per generic formulary retail Plan pharmacy prescription $35 per brand name formulary retail Plan pharmacy prescription 50% per non-formulary retail Plan pharmacy prescription, $50 minimum / $200 maximum $20 per generic formulary mail service prescription $70 per brand name formulary mail service prescription 50% per non-formulary mail service prescription, $100 minimum / $400 maximum 30% up to $150 max per home self injectible prescription 30% up to $150 max per specialty Plan pharmacy prescription (30 days) for specialty drugs

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• Smoking Cessation Medication *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Smoking cessation benefit. (See page 34)*	If the Plan allowance for the prescription at Plan pharmacies is less than the copay, you will pay the lesser amount • No copay for generic, brand name and over-the-counter tobacco cessation medications when prescribed by a physician. If you request a brand name prescription medication over an available generic version then you will be responsible for the generic copayment plus the difference in price of brand name and generic drugs.
Women's contraceptive drugs and devices Note: Over-the-counter female contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider.	No Copayment. However, if a Brand Name contraceptive Drug is requested when a Generic Drug equivalent is available, you will be responsible for paying the difference between the cost to Blue Shield for the Brand Name contraceptive Drug and its Generic Drug equivalent.
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name. If you receive a brand name drug when a federally-approved generic drug is available and your physician has not specified "Dispense as Written" for the brand name drug, you will pay the difference in the cost between the brand name drug and the generic plus the generic copayment.	If you request a brand drug when a generic drug is available: Generic copayment plus the difference in price of brand name and generic drugs
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Compounded medication with formulary alternatives or those with no FDA approved indications* • *Medical supplies such as dressings and antiseptics* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs for weight loss except when Medically Necessary for the treatment of morbid obesity, subject to prior authorization by us.* • *Vitamins and nutritional substances that can be purchased without a prescription* • *Drugs prescribed for the treatment of dental conditions. This exclusion does not apply to antibiotics prescribed to treat infection and medications prescribed to treat pain.*	*All Charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
Note: • *Intravenous fluids and medications for home use and some injectable drugs including office injectables and injectables for the treatment of infertility are not covered under the prescription drug benefit. Please refer to Section 5(a), 5(b) and 5(c) for coverage information.* • *IUDs and implanted contraceptives dispensed by your physician are covered under Section 5(a), not the Prescription Drug Benefit.*	*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 First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan providers must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	**High Option**
The treatment of damage to natural teeth caused solely by an accidental injury is limited to medically necessary services until the services result in initial, palliative stabilization of the member as determined by the Plan. Note: Dental services provided after initial stabilization, prosthodontics, orthodontia and cosmetic services are not covered. The benefit does not include damage to the natural teeth that is not accidental, e.g. resulting from chewing or biting.	$20 per office visit $50 outpatient

Dental benefits

We have no other FEHB dental benefits.

Section 5(h). Special features

Feature	Description
Feature	**High Option**
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
High risk pregnancies	We cover the prenatal diagnosis of genetic disorders of the fetus in high-risk pregnancy cases.
Self-referral to specialty services	Access+ HMO allows you to arrange office visits with Plan specialists in the same Medical Group or IPA as your primary care physician without a referral. A few physicians are not Access+ HMO providers. You are advised to refer to the *Access+ HMO* 2008 *Provider Directory for Federal Employees* to determine if your physician participates in the Access+ HMO self-referral option. Members who use this convenient feature are subject to a $30 copayment per specialty office visit. If the medical condition requires follow-up care to the same specialist, you are encouraged to request that the specialist receive prior authorization from your primary care physicians for additional visits at the regular office copayment of $20 per visit. **The Access+ HMO specialist includes:** • Examinations and consultations; • Conventional x-rays of the chest and abdomen; • X-rays of bones to diagnose suspected fractures;

Feature - continued on next page

Feature	Description
Feature (cont.)	**High Option**
	• Laboratory services; • Diagnostic or treatment procedures that would normally be provided with a referral; and • Vaccines and antibiotics. **The Access+ HMO specialist visit does not include:** • Diagnostic imaging such as CAT Scans, MRI or bone density measurements; • Services that are not covered benefits or that are not medically necessary; • Services of a provider not in the Access+ HMO or MHSA network (see section 5(e)); • Allergy testing; • Endoscopic procedures; • Injectables, chemotherapy or other infusion drugs (not listed above); • Infertility services; • Emergency services; • Urgent care services; • Inpatient services or facility charges; • Services for which the Medical Group or IPA routinely allows the Member to self-refer without authorization from the Personal Physician; • OB/GYN services by an obstetrician/gynecologist or family practice physician within the same Medical Group/IPA as the Personal Physician; and • Internet-based consultations.
NurseHelp 24/7	Blue Shield of California's NurseHelp 24/7 provides members with no charge, confidential, unlimited telephone support for information, consultations, and referrals for health and psychosocial issues. Members may obtain these services by calling 1-877-304-0504, a 24-hour, toll-free telephone number. There is no charge for these services.
Obesity program and educational resources	For members and dependants 18 years and older: • Weight Management program available through MyWellvolution. Visit www.blueshieldca.com/mywellvolution for details • Additional online resources available through Health Library (visit www.blueshieldca.com/federal for details) - interactive tools - actionsets - decision points • Weight Watchers discount also available. See page 60, "Non-FEHB benefits available to Plan members."

Feature - continued on next page

Feature	Description
Feature (cont.)	**High Option**
	For dependant members under age 18: • "What is Your Child's BMI?" Interactive Online Tool • Online Health Library- Video's and Articles detailing causes and risks of childhood obesity and the importance of exercise, nutrition and annual preventive health screenings Visit www.blueshieldca.com/federal for details
Health support programs	Blue Shield of California offers patient education and support programs for certain diagnoses. Programs include: • Asthma Program • Coronary Artery Disease Program • Heart Failure Program • Diabetes Program (including Pediatric Diabetes) • Transplant Care Coordination • COPD Program • Blue Shield Generic Promotion Program • MyWellvolution • Antidepressant Medication Management (AMM) Program • Catastrophic Injury Case Management Program • Complex Case Management Program • Neonatal Intensive Care Unit (NICU) Case Management Program

Non-FEHB benefits available to Plan members

The benefits described on this page are neither offered nor guaranteed under the contract with FEHB, but are made available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Receive Discounts through the Vision Plan Administrator (VPA) on Frames and Lenses. As a Blue Shield of California member, you can enjoy discounts of up to 20% on the following products and services through the VPA discount program: frames and eye glass lenses; contact lenses; photochromatic lenses; and tints and coatings.

For coverage of eye refractions through the VPA see page 31. Most of the providers in the network also agree under their ECN agreement to offer this discount. Vision Plan Administrator provider directories can be accessed through www.blueshieldca.com/federal or ordered by calling Blue Shield Member Service at (800)880-8086.

To receive discounts from VPA providers you simply present your Blue Shield ID card when purchasing the products or services listed here. You pay the participating provider's published fees - less the 20% discount. There is no need to file a claim - you are responsible for all incurred charges.

Receive Discounts through the *mylifepath* Alternative Health Services Discount Program - Acupuncture, Chiropractic and Massage Therapy. We offer the types of non-traditional medical services that our members want, at a generous reduction in cost. They are available nationwide to members with a Blue Shield of California member identification card. Members can get 25 percent off or more from the practitioner's published fees on these alternative care services. You will be responsible for all charges remaining after the discounts are applied. For more details on all features, please call 888-999-9452 or visit our website at www.blueshieldca.com/wellnessdiscounts for health information and news about value-added features, including discounts on memberships at Weight Watchers and 24-Hour Fitness.

Medical Care for Vacations, Business Travel and College Students. You and your eligible family members are covered for urgent and emergency care in all 50 states while you are on vacation or business travel. There are no additional premiums for this coverage. Away from Home Care is also available on a temporary basis for members and dependents who will be living away from home and who need a local primary care provider. You pay office copayments, which vary from state to state ($5 to $25) for guest visits and $15 for urgent care visits. For additional information on these coverages, call 800-622-9402.

Blue Shield offers a variety of health plans for individuals and families. Or, if you are losing this Plan's coverage, you **may** be eligible to apply for one of Blue Shield's individual plans if you meet the eligibility requirements. For more information on all these health plans or to submit an online application, please visit our website at blueshieldca.com.

Benefits on this page are not part of the FEHB Contract

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3** ***When you need prior Plan approval for certain services***

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency services/accidents)
- 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 mental health practice
- Experimental or investigational services except for services for members who have been accepted into an approved clinical trial for cancer as provided under covered services (Section 5(a)). (Also, see specifics regarding transplants in Section 5(b))
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program
- Services, drugs, or supplies related to sexual dysfunction or sexual inadequacies (including penile prostheses) except as provided for medically documented treatment of organically based conditions
- Services performed by a close relative (the spouse, child, brother, sister, or parent of a member) or a person who ordinarily resides in the member's home
- Services, drugs, or supplies you receive without charge while in active military service

Section 7. Filing a claim for covered services

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

There are four types of claims. Three of the four types - Urgent care claims, Pre-service claims, and Concurrent review claims - usually involve access to care where you need to request and receive our advance approval to receive coverage for a particular service or supply covered under this Brochure. See Section 3 for more information on these claims/requests and Section 10 for the definitions of these three types of claims.

The fourth type - Post-service claims - is the claim for payment of benefits after services or supplies have been received.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Facilities will file on the UB-04 form. For claims questions and assistance, contact us at (800) 880-8086 or see our website at www.blueshieldca.com/federal.

When you must file a claim -- such as for out-of-area care -- submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payer -- such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

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

Submit your claims to:

Blue Shield of California
Access+ HMO Member Services
P.O. Box 272550
Chico, CA 95927

Deadline for filing your claim

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

Post-service claims procedures

We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we 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.

Authorized Representative

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

Notice Requirements

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

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

Section 8. The disputed claims process

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

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Blue Shield of California, Member Services Department, P.O. Box 272550, Chico, Ca 95927. You may call our member service department at (800) 880-8086; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
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 on next page

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.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance II, 1900 E Street, NW, Washington, DC 20415-3620.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

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

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

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

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

NOTE: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (800) 880-8086. 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 II at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time.

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

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

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

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

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

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

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

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

Clinical trials

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

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

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

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY: 1-800-486-2048) 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 offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.

- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213, (TTY: 1-800-325-0778).

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 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 don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHBP as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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

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

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

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan primary care physician.

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

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

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at (800) 880-8066.

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

You can find more information about how our plan coordinates benefits with Medicare in "Understanding Your Federal Options" at www.blueshieldca.com/federal.

- **Tell us about your Medicare coverage**

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

- **Medicare Advantage (Part C)**

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

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

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB Plan. In this case, we do not waive cost-sharing for your FEHB coverage.

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

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

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

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

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

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Clinical Trials Cost Categories

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

- Routine Care Costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, 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. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See Section 4.

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

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

Experimental or investigational service

Access+ HMO covers drugs, devices that are medically indicated and biological products no longer considered to be investigational by the Food and Drug Administration. Coverage for other procedures are reviewed by and decided by the Blue Shield of California Medical Policy Committee. The primary criteria are that the proposed new procedures are safe and effective.

Health care professional

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

Medical necessity

Services, drugs, supplies or equipment which are medically necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by us, are:

a. consistent with standards of good medical practices in the U.S.;

b. consistent with the symptoms or diagnosis;

c. not furnished primarily for the convenience of the patient, the attending physician or other provider; and

d. furnished at the most appropriate level, which can be provided safely and effectively to the patient. As an inpatient, this means that your medical symptoms or conditions require that the diagnosis, treatment or service cannot be safely provided to you as an outpatient.

Hospital Inpatient Services which are medically necessary include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in the physician's office, the outpatient department of a hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.

We reserve the right to review all claims to determine whether services are medically necessary, and may use the services of physician consultants, peer review committees of professional societies or hospitals, and other consultants.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. These are negotiated lower provider rates and savings are passed on to you. The plan allowance is the total dollar amount allowed by the Plan for Covered Services, including the amounts payable by the Plan and payable by you.

With respect to Plan Provider and Facilities, the plan allowance is the amount that the Provider and Blue Shield have agreed by contract will be accepted as payment in full for the Services rendered.

Post-service claims

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

Pre-service claims

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

Us/We

Us and we refer to Blue Shield of California Access+ HMO or Blue Shield's Mental Health Services Administrator (MHSA) for mental health and substance abuse coverage.

You

You refers to the enrollee and each covered family member.

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 at (800) 880-8086. 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.

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 dependant 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 taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** - Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **Limited Expense Health Care FSA (LEX HCFSA)** - Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependant Care FSA (DCFSA)** - Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

• **Where can I get more information about FSAFEDS?**	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 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. **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 your choice of either lenses and frames, or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/wision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers. and
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

Allergy.....18,29,30,58
Alternative treatment.....34
Ambulance.....32,44,46,47,48
Anesthesia.....6,37,43,45
Autologous bone marrow transplant.....30
Biopsy.....37
Blood and blood plasma.....45
Breast cancer.....40,42
Business travel.....60,14
Cardiac rehabilitation.....30
Care away from home.....60
Casts.....44,45
Changes for 2015.....15
Chemotherapy.....30,44,58
Childbirth.....8,9,19,26,28,38,62
Chiropractic.....34,60
Cholesterol tests.....27
Claims...10,13,16,19,20,21,24,57,60,62-65,-69-71,73,74
Clinical trials.....19,36,40,41,68,72
Coinsurance.....13,15,16,22,62,70,73
College students.....14,60
Colorectal cancer screening.....27
Congenital anomalies.....37,38
Contraceptive devices and drugs...27,29,53,-54,55
Cost Sharing...22, 26,37, 44,47,49,52,56,70,72,77
Crutches.....33
Definitions...26,37,44,47,49,52,56,62,72,77
Dental care.....77
Diagnostic services...26,27,31,44,45,49,58,75,77
Dialysis.....30,32,44,68
Disposable needles.....53
Disputed claims review.....21,57,60,63-65
Donor expenses (tranplants).....42
Dressings.....44,45,54
Durable medical equipment (DME)...22,32,33
Educational classes and programs...34,35
Effective date of enrollment.....18
Emergency...13,14,16,18,20,47,48,50,53,58-,60,61,62,77
Experimental or investigational.....61,72
Eyeglasses.....31
Family planning.....29
Fecal occult blood test.....27
General exclusions.....61
Hearing services.....31
Home nursing care
Hospice care.....19
Hospital...19,20,21,26,29,32,36,37,38,39,41--46,47,48,50,56,62,64,68,69,72,73,77
Infertility.....15,16,22,29,30,55,58
Inhalation therapy.....30
Insulin.....53
Laboratory and pathology services...45,46
Magnetic Resonance Imaging (MRIs)...2-6,58
Mail service prescription drugs...15,52,53,77
Mammograms.....27
Massage.....34,60
Mastectomies.....32,38
Maternity benefits.....29
Medicaid.....67
Medically necessary...19,26,29,30,31,34,37-,41,44,47,49,52,53,54,56,58,61,72,73
Medicare...0,26,37,44,47,49,52,56,62,67-71
Medicare Advantage plans.....69,70
Mental conditions/substance abuse benefits 15,16,19,49-51,73,77,78
Morbid obesity, surgery.....37,38,54
Newborn care.....26,29,33,37,38,44
Non-FEHB benefits.....34,58,60
Nursery charges.....29,44
Occupational therapy.....30,46
Office visits.....13,15,26,49,57
Oral and maxillofacial surgery.....39
Orthopedic devices.....32
Ostomy and catheter supplies.....32,33
Out-of-area coverage.....54,62,77
Out-of-pocket expenses...8,11,15,22,60,68,-69,72,74,78
Outpatient...32,38,39,43,45,48,49,50,52,56,-72,73,77
Outpatient facility care.....49
Oxygen.....32,33,44,45
Pap test.....27
Physical examination.....13,28
Physical therapy.....35,39,46
Pregnancy, high risk.....57,78
Prescription drugs.....52,54,62,77
Preventive care, adult.....27,28
Preventive care, children.....28,31
Prior authorization...15,19,36,39,41,47,50,5-2,53,54,57
Prostate cancer screening.....27
Prosthetic devices.....31,32,33,38
Radiation therapy.....30,44
Reconstructive surgery.....37,38,39
Renal dialysis.....44
Room and board.....44
Second opinions.....17,18,26
Self-referral option.....57
Service area.....13,14,16,17,18,47,48,70
Skilled nursing facility care.....19,26,43,45
Speech therapy.....31
Splints.....44
Subrogation.....68
Substance abuse.....15,16,19,49,50,51,73,77
Surgery...6,19,30,31,32,37,38,39,44,45,75,77
Syringes.....53
Temporary Continuation of Coverage 5,10,11,71,
Transplants.....19,30,39,40,41,42,61,
Treatment therapies.....30
Vacations.....14,60
Vision services.....31,68
Wheelchairs.....33
Workers' compensation.....66,67,71
X-rays.....26,41,44,45,57,68,72,75

Summary of benefits for the Access+ HMO - 2015

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions , limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- 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.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copayment: $20 primary care; $20 specialist; $30 Access+ HMO self-referral	26
Services provided by a hospital:		
• Inpatient	$200 per day up to 3 days	44
• Outpatient	$250 per treatment or surgery	45
Emergency benefits:		
• In-area or out-of-area	$100 copayment per visit	48
Mental health and substance abuse treatment:		
• In-network	Regular cost-sharing	49
• Out-of-Network	No Benefit	51
Prescription drugs:		
• Retail pharmacy	$10 per generic formulary retail prescription $35 per brand name formulary retail prescription 50% per non-formulary retail prescription, $50 minimum / $200 maximum	53
• Mail service	$20 per generic formulary mail service prescription $70 per brand name formulary mail service prescription 50% per non-formulary mail service prescription, $100 minimum / $400 maximum	53
• Specialty Drugs	30% up to $150 max per home self injectible prescription 30% up to $150 max per specialty Plan pharmacy prescription (30 days) for specialty drugs	53
Dental care:		
• Accidental injury benefit	$20 per office visit, or $50 per treatment or surgery	56
• Optional Non-FEHB Dental Plan	You pay total premiums plus various copayments	60
Vision care:	$20 per office visit	31

High Option Benefits	You pay	Page
Special features: Flexible benefits option, High risk pregnancy program, Access+ HMO self-referral, NurseHelp 24/7, Health support programs	Nothing	57
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)**:**		
• Surgical and medical	Nothing after $3,000/Self Only or $6,000/Family enrollment per year	22
• Mental health and substance abuse	Nothing after $3,000/Self Only or $6,000/Family enrollment per year Some costs do not count toward this protection.	22

Notes

Notes

Notes

2015 Rate Information

For 2015 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.