

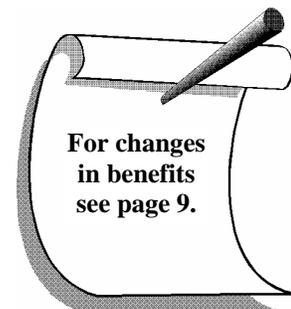


Blue Cross[®] and Blue Shield[®] Service Benefit Plan

<http://www.fepblue.org>

2005

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



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

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the FEHB

Enrollment codes for this Plan:

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



**ACCREDITED
HEALTH WEB SITE**



**ACCREDITED
CASE MANAGEMENT**

This Plan has Health Web Site and Case Management accreditation from URAC (also known as the American Accreditation HealthCare Commission). See the 2005 FEHB Guide for more information on accreditation.

Authorized for distribution by the:



**United States
Office of Personnel Management**
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 71-005



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier life style brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventative screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at www.healthierfeds.opm.gov for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services website on Wellness and Safety, www.hhs.gov/safety/index.html, which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost-effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM Website at www.opm.gov/insure. I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay C. James".

Kay Coles James

Director



Notice of the United States Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

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Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan** under our contract (CS 1039) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan on behalf of the Blue Cross and Blue Shield Association (the Carrier). The address for the Blue Cross and Blue Shield Service Benefit Plan administrative office is:

Blue Cross and Blue Shield Service Benefit Plan

1310 G Street, NW, Suite 900
Washington, DC 20005

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2005, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2005, and changes are summarized on page 9. Rates are shown on the back cover of this brochure.

Plain Language

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

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

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

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized 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) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

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

If the provider does not resolve the matter, call us at 1-800-FEP-8440 (1-800-337-8440) and explain the situation.

If we do not resolve the issue:

**CALL — THE HEALTH CARE FRAUD HOTLINE
202-418-3300**

OR WRITE TO:

**United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100**

- Do not maintain as a family member on your policy:
Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

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 you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.html. 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/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this fee-for-service Plan

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

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

We also have a Preferred Provider Organization (PPO):

Our fee-for-service plan offers services through a PPO. When you use our PPO (Preferred) providers, you will receive covered services at a reduced cost. Your Local Plan (or, for retail pharmacies, Caremark) is solely responsible for the selection of PPO providers in your area. Contact your Local Plan for the names of PPO (Preferred) providers and to verify their continued participation. You can also go to our Web page, which you can reach through the FEHB Web site, www.opm.gov/insure. Contact your Local Plan to request a PPO directory.

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

Under Basic Option, you must use Preferred providers in order to receive benefits. See page 12 for the exceptions to this requirement.

How we pay professional and facility providers

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

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

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

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

You must pay any difference between the amount Non-participating providers charge and our allowance (except in certain circumstances – see page 114). In addition, you must pay any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for noncovered services. **Important: Under Standard Option, your out-of-pocket costs may be substantially higher when you use Non-participating providers than when you use Preferred or Participating providers.** Under Basic Option, you must use Preferred providers to receive benefits. See page 12 for the exceptions to this requirement.

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

Your Rights

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

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

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

Section 2. How we change for 2005

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

Program-wide changes

- In Section 3, under **Covered providers**, Alaska is designated as a medically underserved area in 2005. Maine, Utah, and West Virginia are no longer designated as medically underserved areas in 2005.
- In Section 9, we revised the **Medicare Primary Payer Chart** and updated the language regarding Medicare Advantage plans (formerly called Medicare + Choice plans).
- In Section 12, we revised the language regarding the Flexible Spending Account Program – *FSAFEDS* and the Federal Long Term Care Insurance Program.

Changes to this Plan

- Under Standard Option, your share of the non-Postal premium will increase by 3.7% for Self Only or 4.6% for Self and Family.
- Under Basic Option, your share of the non-Postal premium will not change for Self Only or for Self and Family.
- For certain claims for services from Non-participating professional providers, your responsibility for the difference between our allowance and the provider's billed amount may be limited to \$5,000. [See Section 10.]
- We now provide benefits for continuous passive motion (CPM) devices and dynamic orthotic cranioplasty (DOC) devices. [See Section 5(a).]
- We now provide benefits for general health panels when performed as part of routine (screening) physical examinations. [See Section 5(a).]
- We now provide benefits for inpatient and outpatient nutritional counseling for the treatment of anorexia and bulimia. [See Sections 5(a) and 5(c).]
- Under Standard Option, we now provide benefits in full for neurological/psychological testing you receive from Preferred providers after you pay a \$15 copayment for the associated office visit charge (no deductible). [See Sections 5(a) and 5(e).]
- Under Standard Option, we now provide benefits for 75 visits per year for physical, occupational, or speech therapy, or a combination of all three types of therapy, subject to a \$15 copayment per visit when you receive these therapies from Preferred providers. Previously, we paid benefits for these therapies at 90% of the Plan allowance after your Standard Option calendar year deductible had been met and limited benefits to 50 visits per person, per calendar year for physical therapy and 25 visits per person, per calendar year for occupational therapy or speech therapy, or a combination of both. [See Section 5(a).]
- Under Standard Option, we eliminated the three-year limitation for routine physical examinations performed by Preferred providers. [See Section 5(a).]
- Under Standard Option, we eliminated the frequency and age limits for cancer screenings performed by Participating and Non-participating providers. [See Section 5(a).]
- Under Standard Option, we now provide benefits in full for eye examinations related to a specific medical condition when performed by Preferred providers after you pay a \$15 copayment (no deductible). Previously, we provided benefits at 90% of the Plan allowance for these types of examinations after your Standard Option calendar year deductible had been met. [See Section 5(a).]
- Under Basic Option, we now provide benefits in full for professional maternity care delivery. Previously, benefits for maternity care delivery were subject to a \$100 copayment. [See Section 5(a).]
- Under Basic Option, we now provide benefits in full for laboratory tests, X-rays, and other diagnostic tests billed by Preferred professional providers and Preferred independent laboratories. Previously, these benefits were subject to a \$20 copayment. [See Section 5(a).]
- Under Basic Option, we now provide benefits in full for outpatient facility services and medical supplies subject to a \$40 per day per facility copayment. Previously, outpatient facility services were subject to a \$30 copayment per day per facility and benefits for the supplies were provided at 70% of the Plan allowance. [See Section 5(c).]
- Under Standard and Basic Options, Caremark is now our Pharmacy Benefit Manager for the Retail Pharmacy Program.
- Under Standard Option, Caremark is now our Pharmacy Benefit Manager for the Mail Service Prescription Drug Program. [See Section 5(f) and Section 7.]
- We now offer a Web-accessible option for the visually impaired on our Web site, www.fepblue.org. [See Section 5(g).]

Section 3. How you receive benefits

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call the Local Plan serving the area where you reside and ask them to assist you, or write to us directly at: FEP Enrollment Services, 840 First Street, NE, Washington, DC 20065. You may also request replacement cards through our Web site, www.fepblue.org.

Where you get covered care

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

Under Basic Option, you **must** use those “covered professional providers” or “covered facility providers” that are **Preferred providers** for Basic Option in order to receive benefits. Please refer to page 12 for the exceptions to this requirement. Refer to page 7 for more information about Preferred providers.

For Basic Option, the term “primary care provider” includes family practitioners, general practitioners, medical internists, pediatricians, obstetricians/gynecologists, and physician assistants.

• Covered professional providers

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

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

Other Covered Health Care Professionals – Professionals who provide additional covered services and meet the state’s applicable licensing or certification requirements and the requirements of the Local Plan. Other covered health care professionals include:

- **Audiologist** – A professional who, if the state requires it, is licensed, certified, or registered as an audiologist where the services are performed.
- **Clinical Psychologist** – A psychologist who (1) is licensed or certified in the state where the services are performed; (2) has a doctoral degree in psychology (or an allied degree if, in the individual state, the academic licensing/certification requirement for clinical psychologist is met by an allied degree) or is approved by the Local Plan; and (3) has met the clinical psychological experience requirements of the individual State Licensing Board.
- **Clinical Social Worker** – A social worker who (1) has a master’s or doctoral degree in social work; (2) has at least two years of clinical social work practice; and (3) if the state requires it, is licensed, certified, or registered as a social worker where the services are performed.
- **Diabetic educator** – A professional who, if the state requires it, is licensed, certified, or registered as a diabetic educator where the services are performed.
- **Dietician** – A professional who, if the state requires it, is licensed, certified, or registered as a dietician where the services are performed.
- **Independent Laboratory** – A laboratory that is licensed under state law or, where no licensing requirement exists, that is approved by the Local Plan.
- **Nurse Midwife** – A person who is certified by the American College of Nurse Midwives or, if the state requires it, is licensed or certified as a nurse midwife.
- **Nurse Practitioner/Clinical Specialist** – A person who (1) has an active R.N. license in the United States; (2) has a baccalaureate or higher degree in nursing; and (3) if the state requires it, is licensed or certified as a nurse practitioner or clinical nurse specialist.

- **Nursing School Administered Clinic** – A clinic that (1) is licensed or certified in the state where services are performed; and (2) provides ambulatory care in an outpatient setting – primarily in rural or inner-city areas where there is a shortage of physicians. Services billed for by these clinics are considered outpatient “office” services rather than facility charges.
- **Nutritionist** – A professional who, if the state requires it, is licensed, certified, or registered as a nutritionist where the services are performed.
- **Physical, Speech, and Occupational Therapist** – A professional who is licensed where the services are performed or meets the requirements of the Local Plan to provide physical, speech, or occupational therapy services.
- **Physician Assistant** – A person who is nationally certified by the National Commission on Certification of Physician Assistants in conjunction with the National Board of Medical Examiners or, if the state requires it, is licensed, certified, or registered as a physician assistant where the services are performed.
- **Other professional providers** specifically shown in the benefit descriptions in Section 5.

Medically underserved areas. In states that OPM determines are “medically underserved”:

Under Standard Option, we cover any licensed medical practitioner for any covered service performed within the scope of that license.

Under Basic Option, we cover any licensed medical practitioner who is **Preferred** for any covered service performed within the scope of that license.

For 2005, the states are: Alabama, Alaska, Idaho, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, and Wyoming.

- **Covered facility providers**

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

- **Hospital** – An institution, or a distinct portion of an institution, that:
 - (1) Primarily provides diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of injured and sick persons provided or supervised by a staff of licensed doctors of medicine (M.D.) or licensed doctors of osteopathy (D.O.), for compensation from its patients, on an inpatient or outpatient basis;
 - (2) Continuously provides 24-hour-a-day professional registered nursing (R.N.) services; and
 - (3) Is not, other than incidentally, an extended care facility; a nursing home; a place for rest; an institution for exceptional children, the aged, drug addicts, or alcoholics; or a custodial or domiciliary institution having as its primary purpose the furnishing of food, shelter, training, or non-medical personal services.

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

- **Freestanding Ambulatory Facility** – A freestanding facility, such as an ambulatory surgical center, freestanding surgi-center, freestanding dialysis center, or freestanding ambulatory medical facility, that:
 - (1) Provides services in an outpatient setting;
 - (2) Contains permanent amenities and equipment primarily for the purpose of performing medical, surgical, and/or renal dialysis procedures;
 - (3) Provides treatment performed or supervised by doctors and/or nurses, and may include other professional services performed at the facility; and
 - (4) Is not, other than incidentally, an office or clinic for the private practice of a doctor or other professional.

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

- **Blue Quality Centers for Transplant (BQCT)**

In addition to Preferred transplant facilities, you have access to the Blue Quality Centers for Transplant (BQCT), a centers of excellence program. BQCT institutions are selected based on their ability to meet defined clinical quality criteria that are unique for each type of transplant. BQCT negotiates a payment for transplant services performed during the transplant period (see page 114 for the definition of “transplant period”).

Members who choose to use a BQCT facility for a covered transplant only pay the \$100 per admission copayment under Standard Option, or the \$100 per day copayment (\$500 maximum) under Basic Option, for the transplant period. Members are not responsible for additional costs for included professional services. Regular Preferred benefits (subject to the regular cost-sharing levels for facility and professional services) are paid for pre- and post-transplant services performed in BQCT facilities before and after the transplant period.

BQCT institutions are available for seven types of transplants: heart; heart-lung; single or bilateral lung; liver; pancreas; simultaneous pancreas-kidney; and autologous or allogeneic bone marrow (see pages 53 through 55 for limitations).

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

- **Cancer Research Facility** – A facility that is:

- (1) A National Cooperative Cancer Study Group institution that is funded by the National Cancer Institute (NCI) and has been approved by a Cooperative Group as a bone marrow transplant center;
- (2) An NCI-designated Cancer Center; or
- (3) An institution that has a peer-reviewed grant funded by the National Cancer Institute (NCI) or National Institutes of Health (NIH) to study allogeneic or autologous bone marrow transplants and blood stem cell transplant support.

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

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

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

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

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

What you must do to get covered care

- **Transitional care**

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

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

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

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

- **Hospital care**

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

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

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

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

How to get approval for . . .

- **Your hospital stay**

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

In most cases, your physician or hospital will take care of precertification. Because you are still responsible for ensuring that we are asked to precertify your care, you should always ask your physician or hospital whether they have contacted us.

Warning:

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

How to precertify an admission

- You, your representative, your doctor, or your hospital must call us at the telephone number listed on the back of your Service Benefit Plan ID card any time prior to admission.
- 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, your doctor, or your hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
 - Enrollee's name and Plan identification number;

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

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

Maternity care

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

If your hospital stay needs to be extended:

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

What happens when you do not follow the precertification rules

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

- If we determine that the stay was medically necessary, we will pay the inpatient charges, less the \$500 penalty. [See Section 5(c) for payment information.]
- If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

If we denied the precertification request, we will not pay inpatient hospital benefits or inpatient physician care benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

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

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

Exceptions:

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payer for the hospital stay. (See page 12 for special instructions regarding admissions to BQCT institutions.)
- Your Medicare Part A is the primary payer for the hospital stay. (See page 12 for special instructions regarding admissions to BQCT institutions.)

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

• **Other services**

These services require prior approval under both Standard and Basic Option:

- **Home hospice care** – Contact us at the customer service number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination and advise you which home hospice care agencies we have approved.

- **Partial hospitalization or intensive outpatient treatment for mental health/substance abuse** – Contact us at the mental health and substance abuse number listed on the back of your ID card before obtaining services for intensive outpatient treatment or partial hospitalization from Preferred providers. We will request the medical evidence we need to make our coverage determination. We will also consider the necessary duration of either of these services.
- **Organ/tissue transplants** – Contact us at the customer service number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination. We will consider whether the facility is approved for the procedure and whether you meet the facility’s criteria.
- **Clinical trials for certain organ/tissue transplants** – Contact our Clinical Trials Information Unit at 1-800-225-2268 for information or to request prior approval before obtaining services. We will request the medical evidence we need to make our coverage determination. Use this number **only** for prior approval of clinical trials for bone marrow and peripheral blood stem cell transplant support procedures for those conditions shown on pages 54 and 55 as covered only in clinical trials.
- **Prescription drugs** – Certain prescription drugs require prior approval. Contact our Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077 for the hearing impaired) to request prior approval, or to obtain an updated list of prescription drugs that require prior approval. We will request the information we need to make our coverage determination. You must periodically renew prior approval for certain drugs. See page 85 for more about our prescription drug prior approval program, which is part of our Patient Safety and Quality Monitoring (PSQM) program.

Note: Benefits for drugs to aid smoking cessation that require a prescription by Federal law are limited to one course of treatment per calendar year. Prior approval is required before benefits will be provided for additional medication. To obtain approval, the physician must certify the patient is participating in a smoking cessation program that provides clinical treatment, including counseling and behavioral therapies.

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

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

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

In addition to the types of care listed above, these services also require prior approval under Basic Option:

- **Outpatient mental health and substance abuse treatment** – **You must call us** at the number listed on the back of your ID card for mental health and substance abuse **before receiving any outpatient professional or facility care**. We will then provide you with the names and phone numbers of several Preferred providers to choose from and tell you how many visits we are initially approving.

Section 4. Your costs for covered services

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

Copayments

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

Example: If you have Standard Option when you see your Preferred physician, you pay a copayment of \$15 for the office visit and we then pay the remainder of the amount billed for the office visit. (You may have to pay separately for other services you receive while in the physician's office.) When you go into a Preferred hospital, you pay a copayment of \$100 per admission. We then pay the remainder of the hospital bill for the covered services you receive.

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

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

Deductible

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

Under Standard Option, the calendar year deductible is \$250 per person. Under a family enrollment, the calendar year deductible for each family member is satisfied and benefits are payable for all family members when the combined covered expenses of the family reach \$500.

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

Example: If the billed amount is \$100, the provider has an agreement with us to accept \$80, and you have not paid any amount toward meeting your Standard Option calendar year deductible, you must pay \$80. We will apply \$80 to your deductible. We will begin paying benefits once the remaining portion of your Standard Option calendar year deductible (\$170) has been satisfied.

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

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

Coinsurance

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

Example: You pay 10% of the Plan allowance under Standard Option for durable medical equipment obtained from a Preferred provider, after meeting your \$250 calendar year deductible.

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

Example: If your physician ordinarily charges \$100 for a service but routinely waives your 25% Standard Option coinsurance, the actual charge is \$75. We will pay \$56.25 (75% of the actual charge of \$75).

Waivers

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

Differences between our allowance and the bill

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

Often, the provider’s bill is more than a fee-for-service plan’s allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the type of provider you use. In this Plan, we have the following types of providers:

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

Under Standard Option, your share consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a Preferred physician who charges \$150, but our allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 10% of our \$100 allowance (\$10). Because of the agreement, your Preferred physician will not bill you for the \$50 difference between our allowance and his/her bill.

Under Basic Option, your share consists only of your copayment or coinsurance amount, since there is no calendar year deductible. Here is an example involving a copayment: You see a Preferred physician who charges \$150 for covered services subject to a \$20 copayment. Even though our allowance may be \$100, you still pay just the \$20 copayment. Because of the agreement, your Preferred physician will not bill you for the \$130 difference between your copayment and his/her bill.

Remember, under Basic Option, you must use Preferred providers in order to receive benefits. See page 12 for the exceptions to this requirement.

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

Under Standard Option, when you use a Participating provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example: You see a Participating physician who charges \$150, but the Plan allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 25% of our \$100 allowance (\$25). Because of the agreement, your Participating physician will not bill you for the \$50 difference between our allowance and his/her bill.

Under Basic Option, there are no benefits for care performed by Participating providers; you pay all charges. See page 12 for the exceptions to this requirement.

- **Non-participating providers.** These **Non-preferred providers** have no agreement to limit what they will bill you.

Under Standard Option, when you use a Non-participating provider, you will pay your deductible and coinsurance – **plus** any difference between our allowance and the charges on the bill (except in certain circumstances – see page 114). For example, you see a Non-participating physician who charges \$150. The Plan allowance is again \$100, and you have met your deductible. You are responsible for your coinsurance, so you pay 25% of the \$100 Plan allowance or \$25. Plus, because there is no agreement between the Non-participating physician and us, the physician can bill you for the \$50 difference between our allowance and his/her bill.

Under Basic Option, there are no benefits for care performed by Non-participating providers; you pay all charges. See page 12 for the exceptions to this requirement.

The following table illustrates examples of how much you have to pay out-of-pocket for services from a Preferred physician, a Participating physician, and a Non-participating physician. The table uses our example of a service for which the physician charges \$150 and the Plan allowance is \$100. For Standard Option, the table shows the amount you pay if you have met your calendar year deductible.

EXAMPLE	Preferred physician Standard Option	Preferred physician Basic Option	Participating physician (Standard Option*)	Non-participating physician (Standard Option*)
Physician's charge	\$150	\$150	\$150	\$150
Our allowance	We set it at: 100	We set it at: 100	We set it at: 100	We set it at: 100
We pay	90% of our allowance: 90	Our allowance less copay: 80	75% of our allowance: 75	75% of our allowance: 75
You owe: Coinsurance	10% of our allowance: 10	Not applicable	25% of our allowance: 25	25% of our allowance: 25
You owe: Copayment	Not applicable	20	Not applicable	Not applicable
+Difference up to charge?	No: 0	No: 0	No: 0	Yes: 50
TOTAL YOU PAY	\$10	\$20	\$25	\$75

***Under Basic Option, there are no benefits for care performed by Participating and Non-participating physicians. You must use Preferred providers in order to receive benefits.** See page 12 for the exceptions to this requirement.

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

- **Overseas providers.** We pay overseas claims at Preferred benefit levels, using an Overseas Fee Schedule as our Plan allowance. Most overseas professional providers are under no obligation to accept our allowance, and you must pay any difference between our payment and the provider's bill. For facility care you receive overseas, we provide benefits in full after you pay the applicable copayment or coinsurance (and, under Standard Option, any deductible amount that may apply). See Section 5(i) for more information about our overseas benefits.
- **Dental care.** Under Standard Option, we pay scheduled amounts for routine dental services and you pay any balance. Under Basic Option, you pay \$20 for any covered evaluation and we pay the balance for covered services. See Section 5(h) for a listing of covered dental services and additional payment information.

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

- **Hospital care.** You pay the coinsurance or copayment amounts listed in Section 5(c). **Under Standard Option**, you must meet your deductible before we begin providing benefits for certain hospital-billed services. **Under Basic Option**, you must use **Preferred** facilities in order to receive benefits. See page 12 for the exceptions to this requirement.

If the total amount of out-of-pocket expenses in a calendar year for you and your covered family members for deductibles (Standard Option only), coinsurance, and copayments (other than those listed below) exceeds \$6,000 under Standard Option, or \$5,000 under Basic Option, then you and any covered family members will not have to continue paying them for the remainder of the calendar year.

Standard Option Preferred maximum: If the total amount of these out-of-pocket expenses from using Preferred providers for you and your covered family members exceeds \$4,000 in a calendar year under Standard Option, then you and any covered family members will not have to pay these expenses for the remainder of the calendar year when you continue to use Preferred providers. You will, however, have to pay them when you use Non-preferred providers, until your out-of-pocket expenses (for the services of both Preferred and Non-preferred providers) reach \$6,000 under Standard Option, as shown above.

Basic Option maximum: If the total amount of these out-of-pocket expenses from using Preferred providers for you and your covered family members exceeds \$5,000 in a calendar year under Basic Option, then you and any covered family members will not have to pay these expenses for the remainder of the calendar year.

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

- The difference between the Plan allowance and the billed amount. See pages 17-19;
- Expenses for services, drugs, and supplies in excess of our maximum benefit limitations;
- Under Standard Option, your 30% coinsurance for inpatient care in a Non-member hospital;
- Under Standard Option, your 25% coinsurance for outpatient care by a Non-member facility;
- Your expenses for mental conditions and substance abuse care by a Non-preferred professional or facility provider;
- Your expenses for dental services in excess of our fee schedule payments under Standard Option. See Section 5(h);
- The \$500 penalty for failing to obtain precertification, and any other amounts you pay because we reduce benefits for not complying with our cost containment requirements;
- Under Basic Option, coinsurance you pay for non-formulary brand-name drugs; and
- Under Basic Option, your expenses for care received from Participating/Non-participating professional providers or Member/Non-member facilities, except for coinsurance and copayments you pay in those special situations where we do pay for care provided by Non-preferred providers. Please see page 12 for the exceptions to the requirement to use Preferred providers.

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

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

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

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

When Government facilities bill us

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

If we overpay you

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

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

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

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

If you...

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

Then, for your inpatient hospital care,

- the law requires us to base our payment on an amount – the “equivalent Medicare amount” – set by Medicare’s rules for what Medicare would pay, not on the actual charge;
- you are responsible for your deductible (Standard Option only), coinsurance, or copayments you owe under this Plan;
- you are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you; and
- the law prohibits a hospital from collecting more than the equivalent Medicare amount.

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

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

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

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

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

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

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

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

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

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

Note: Under Basic Option, you must see **Preferred** providers in order to receive benefits. See page 12 for the exceptions to this requirement.

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

Please see Section 9, *Coordinating benefits with other coverage*, for more information about how we coordinate benefits with Medicare.

Section 5. Benefits – OVERVIEW

(See page 9 for how our benefits changed this year and pages 123-124 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 at the customer service telephone number on the back of your Service Benefit Plan ID card or at our Web site at www.fepblue.org.

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

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Here are some 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.
- **Under Standard Option**, the calendar year deductible is \$250 per person (\$500 per family). The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under Standard Option**, we provide benefits at 90% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician’s office). You are responsible for any difference between our allowance and the billed amount.
- **Under Basic Option**, there is **no calendar year deductible**.
- **Under Basic Option**, you must use **Preferred providers in order to receive benefits. See below and page 12 for the exceptions to this requirement.**
- **Under Basic Option**, we provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician’s office). You are responsible for any difference between our allowance and the billed amount.
- Please refer to Section 3, *How you receive benefits*, for a list of providers we consider to be primary care providers (under Basic Option) and other health care professionals.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.
- The amounts listed in this section are for the charges billed by a physician or other health care professional for your medical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital or other outpatient facility, etc.).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Benefit Description	You Pay	
<p>Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does <i>not</i> apply. There is no calendar year deductible under Basic Option.</p>		
Diagnostic and treatment services	You Pay – Standard Option	You Pay – Basic Option
<p>Professional services of physicians and other health care professionals:</p> <ul style="list-style-type: none"> • Outpatient consultations • Outpatient second surgical opinions • Office visits • Home visits • Initial examination of a newborn needing definitive treatment when covered under a family enrollment • Pharmacotherapy [see Section 5(f) for prescription drug coverage] • Neurological testing 	<p>Preferred: \$15 copayment for the office visit charge (No deductible)</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p>

Diagnostic and treatment services – *continued on next page*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Diagnostic and treatment services (continued)	You Pay – Standard Option	You Pay – Basic Option
<p>Inpatient professional services:</p> <ul style="list-style-type: none"> • During a hospital stay • Services for nonsurgical procedures when ordered, provided, and billed by a physician during a covered inpatient hospital admission • Medical care by the attending physician (the physician who is primarily responsible for your care when you are hospitalized) on days we pay inpatient hospital benefits <p><i>Note:</i> A consulting physician employed by the hospital is not the attending physician.</p> <ul style="list-style-type: none"> • Consultations when requested by the attending physician • Concurrent care – hospital inpatient care by a physician other than the attending physician for a condition not related to your primary diagnosis, or because the medical complexity of your condition requires this additional medical care • Physical therapy by a physician other than the attending physician • Initial examination of a newborn needing definitive treatment when covered under a family enrollment • Pharmacotherapy [see Section 5(c) for prescription drug coverage] • Neurological testing • Second surgical opinion • Nutritional counseling when billed by a covered provider for anorexia and bulimia 	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>

Diagnostic and treatment services – *continued on next page*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Diagnostic and treatment services (continued)	You Pay – Standard Option	You Pay – Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Routine services except for those Preventive care services described below, on pages 29-31, and page 46 • Inpatient private duty nursing • Standby physicians • Routine radiological and staff consultations required by hospital rules and regulations • Inpatient physician care when your hospital admission or portion of an admission is not covered [see Section 5(c)] <p>Note: If we determine that a hospital admission is not covered, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.</p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Lab, X-ray, and other diagnostic tests		
<p>Diagnostic tests provided, or ordered and billed by a physician, such as:</p> <ul style="list-style-type: none"> • Blood tests • Bone density tests – screening or diagnostic • CT scans/MRIs • EKGs and EEGs • Laboratory tests • Pathology services • Ultrasounds • Urinalysis • X-rays <p>Diagnostic services billed by an independent laboratory</p> <p>Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.</p>	<p>Preferred primary care provider or other health care professional: Nothing</p> <p>Preferred specialist: Nothing</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p>

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

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Lab, X-ray, and other diagnostic tests (continued)	You Pay – Standard Option	You Pay – Basic Option
<p>Other diagnostic tests provided, or ordered and billed by a physician, such as:</p> <ul style="list-style-type: none"> • Fecal occult blood tests • Non-routine mammograms • Non-routine Pap tests • Prostate Specific Antigen (PSA) tests • Sigmoidoscopies <p>Note: See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.</p>	<p>Preferred: \$15 copayment for associated office visits (No deductible); nothing for services or tests</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.</p>	<p>Preferred primary care provider or other health care professional: Nothing</p> <p>Preferred specialist: Nothing</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p>
<p>Preventive care, adult</p> <p>Home and office visits for routine (screening) physical examinations</p> <p>Under Standard Option, benefits are limited to the following services when performed as part of a routine physical examination:</p> <ul style="list-style-type: none"> • History and risk assessment • Chest X-ray • EKG • Urinalysis • General health panel • Basic or comprehensive metabolic panel test • CBC • Fasting lipoprotein profile (total cholesterol, LDL, HDL, and/or triglycerides) when performed by a Preferred provider or any independent laboratory <p>Note: The benefits listed above do not apply to children up to age 22. (See benefits under <i>Preventive care, children</i>, this section.)</p> <ul style="list-style-type: none"> • Chlamydial infection test <p>Under Basic Option, benefits are provided for all of the services listed above and for other appropriate screening tests and services.</p>	<p>Preferred: \$15 copayment for the examination (No deductible); nothing for services or tests</p> <p>Note: We provide benefits for adult routine physical examinations only when you receive these services from a Preferred provider.</p> <p>Participating: You pay all charges</p> <p>Non-participating: You pay all charges</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p> <p>Note: See Section 5(c) for our payment levels for these services when billed for by a facility, such as the outpatient department of a hospital.</p>

Preventive care, adult – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Preventive care, adult <i>(continued)</i>	You Pay – Standard Option	You Pay – Basic Option
<p>Cancer screening</p> <ul style="list-style-type: none"> • Colorectal cancer screening, including: <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy – Double contrast barium enema • Prostate cancer screening – Prostate Specific Antigen (PSA) test • Cervical cancer screening • Breast cancer screening (routine mammograms) 	<p>Preferred: \$15 copayment for associated office visits (No deductible); nothing for services or tests</p> <p>Note: We provide benefits in full for preventive (screening) tests and immunizations only when you receive these services from a Preferred provider on an outpatient basis. If these services are billed separately from the routine physical examination, you may be responsible for paying an additional copayment for each office visit billed.</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p> <p>Note: See Section 5(c) for our payment levels for these services when billed for by a facility, such as the outpatient department of a hospital.</p>

Preventive care, adult – *continued on next page*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Preventive care, adult <i>(continued)</i>	You Pay – Standard Option	You Pay – Basic Option
Routine immunizations without regard to age, limited to: <ul style="list-style-type: none"> • Hepatitis immunizations (Types A and B) for patients with increased risk or family history • Influenza and pneumococcal vaccines, annually • Tetanus-diphtheria (Td) booster – once every 10 years 	Preferred: \$15 copayment for associated office visits (No deductible); nothing for immunizations Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: \$20 copayment for associated office visits; nothing for immunizations Preferred specialist: \$30 copayment for associated office visits; nothing for immunizations Participating/Non-participating: You pay all charges
<i>Not covered: Office visit charges associated with preventive services and routine immunizations performed by Participating and Non-participating providers</i>	<i>All charges</i>	<i>All charges</i>
Preventive care, children		
We provide benefits for the following services: <ul style="list-style-type: none"> • All healthy newborn visits including routine screening (inpatient or outpatient) • The following routine services as recommended by the American Academy of Pediatrics for children up to the age of 22, including children living, traveling, or adopted from outside the United States: <ul style="list-style-type: none"> – Routine physical examinations – Routine hearing tests – Laboratory tests – Immunizations – Related office visits 	Preferred: Nothing (No deductible) Participating: Nothing (No deductible) Non-participating: Nothing (No deductible) up to the Plan allowance. You are responsible only for any difference between our allowance and the billed amount. Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: Nothing Preferred specialist: Nothing Participating/Non-participating: You pay all charges Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Maternity care	You Pay – Standard Option	You Pay – Basic Option
<p>Complete maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage when provided, or ordered and billed by a physician or nurse midwife, such as:</p> <ul style="list-style-type: none"> • Prenatal care (including laboratory and diagnostic tests) • Tocolytic therapy and related services (when provided and billed by a home infusion therapy company or a home health care agency) <p><i>Note:</i> Benefits are not provided for oral tocolytic agents. Benefits for home nursing visits related to covered tocolytic therapy are subject to the visit limitations described on page 42.</p> <ul style="list-style-type: none"> • Delivery • Postpartum care • Assistant surgeons/surgical assistance by a physician if required because of the complexity of the delivery • Anesthesia (including acupuncture) when requested by the attending physician and performed by a certified registered nurse anesthetist (CRNA) or a physician other than the operating physician (surgeon) or the assistant 	<p>Preferred: Nothing (No deductible)</p> <p><i>Note:</i> For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use Preferred providers.</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p><i>Note:</i> For facility care related to maternity, including care at birthing facilities, see Section 5(c).</p> <p>Participating/Non-participating: You pay all charges</p> <p><i>Note:</i> For services billed by Participating and Non-participating laboratories and radiologists, you are responsible only for any difference between our allowance and the billed amount.</p>

Maternity care – *continued on next page*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Maternity care (continued)	You Pay – Standard Option	You Pay – Basic Option
<p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 14 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you, your representative, your doctor, or your hospital must precertify the extended stay. See Section 3 for information on requesting additional days. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay, or if the child is covered under the father's Self and Family enrollment. <p>Note: When a newborn requires definitive treatment including incubation charges by reason of prematurity or evaluation for medical or surgical reasons during or after the mother's confinement, the newborn is considered a patient in his or her own right.</p> <p>Note: Expenses of the newborn are eligible for benefits only if the child is covered by a Self and Family enrollment. For services such as circumcision, regular medical or surgical benefits apply rather than maternity benefits.</p> <p>Note: See page 46 for our payment levels for circumcision.</p>		
<p><i>Not covered: Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest</i></p>	<i>All charges</i>	<i>All charges</i>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Family planning	You Pay – Standard Option	You Pay – Basic Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Depo-Provera • Diaphragms and contraceptive rings • Intrauterine devices (IUDs) • Implantable contraceptives • Oral and transdermal contraceptives • Voluntary sterilization [see Surgical procedures in Section 5(b)] <p>Note: See Section 5(f) for prescription drug coverage.</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay \$100 for related surgical procedures. See Section 5(b) for our coverage for related surgical procedures.</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Reversal of voluntary surgical sterilization • Contraceptive devices not described above 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Infertility services		
<p>Diagnosis and treatment of infertility, except as shown in <i>Not Covered</i></p> <p>Note: See Section 5(f) for prescription drug coverage.</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p>

Infertility services – *continued on next page*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Infertility services (continued)	You Pay – Standard Option	You Pay – Basic Option
<p>Not covered:</p> <ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> – artificial insemination (AI) – in vitro fertilization (IVF) – embryo transfer and Gamete Intrafallopian Transfer (GIFT) – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) • Services and supplies related to ART procedures, such as sperm banking 	<p>All charges</p>	<p>All charges</p>
<p>Allergy care</p> <ul style="list-style-type: none"> • Testing and treatment, including materials (such as allergy serum) • Allergy injections 	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit; nothing for injections</p> <p>Preferred specialist: \$30 copayment per visit; nothing for injections</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.</p>
<p>Not covered: Provocative food testing and sublingual allergy desensitization</p>	<p>All charges</p>	<p>All charges</p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Treatment therapies	You Pay – Standard Option	You Pay – Basic Option
<p>Outpatient treatment therapies:</p> <ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p><i>Note:</i> We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under Organ/tissue transplants in Section 5(b). See also, <i>Other services</i> under <i>How to get approval for . . .</i> in Section 3 (page 14).</p> <ul style="list-style-type: none"> • Renal dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy – Home IV or infusion therapy <p><i>Note:</i> Home nursing visits associated with Home IV/infusion therapy are covered as shown under Home health services on page 42.</p> <ul style="list-style-type: none"> • Outpatient cardiac rehabilitation <p><i>Note:</i> See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital.</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p><i>Note:</i> You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p>
<p>Inpatient treatment therapies:</p> <ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p><i>Note:</i> We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under Organ/tissue transplants in Section 5(b). See also, <i>Other services</i> under <i>How to get approval for . . .</i> in Section 3 (page 14).</p> <ul style="list-style-type: none"> • Renal dialysis – Hemodialysis and peritoneal dialysis • Pharmacotherapy [see Section 5(c) for prescription drug coverage] 	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Rehabilitative therapies	You Pay – Standard Option	You Pay – Basic Option
<ul style="list-style-type: none"> • Physical therapy, occupational therapy, and speech therapy when performed by a licensed therapist or physician • Acupuncture when provided by a physician <p>Note: When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for professional care, according to the contracting status of the therapist.</p>	<p>Preferred: \$15 copayment per visit (No deductible)</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p>Note: Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three.</p> <p>Note: Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.</p> <p>Note: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Note: Benefits are limited to 50 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three.</p> <p>Participating/Non-participating: You pay all charges</p> <p>Note: See Section 5(c) for our payment levels for rehabilitative therapies billed for by the outpatient department of a hospital.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay</i> • <i>Maintenance or palliative rehabilitative therapy</i> • <i>Exercise programs</i> • <i>Hippotherapy (exercise on horseback)</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Hearing services (testing, treatment, and supplies)	You Pay – Standard Option	You Pay – Basic Option
<p>Hearing tests related to illness or injury</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Routine hearing tests (except as indicated under Preventive care, children) • Hearing aids (including implanted bone conduction hearing aids) • Testing and examinations for the prescribing or fitting of hearing aids 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Vision services (testing, treatment, and supplies)		
<ul style="list-style-type: none"> • One pair of eyeglasses, replacement lenses, or contact lenses to correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery <p>Note: This benefit may also be used to obtain one pair of eyeglasses, replacement lenses, or contact lenses prescribed in lieu of surgery when the condition can be corrected by surgery, but surgery is precluded because of age or medical condition.</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p>
<ul style="list-style-type: none"> • Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 12 <p>Note: See Section 5(b), <i>Surgical procedures</i>, for coverage for surgical treatment of amblyopia and strabismus.</p>	<p>Preferred: \$15 copayment (No deductible)</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p>

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

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Vision services (testing, treatment, and supplies) (continued)	You Pay – Standard Option	You Pay – Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as described on page 38</i> • <i>Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described on page 38</i> • <i>LASIK, radial keratotomy, and other refractive services</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p>Foot care</p> <p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p> <p>Note: See Section 5(b) for our coverage for surgical procedures.</p>	<p>Preferred: \$15 copayment for the office visit (No deductible); 10% of the Plan allowance for all other services (deductible applies)</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered: Routine foot care, such as cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Orthopedic and prosthetic devices	You Pay – Standard Option	You Pay – Basic Option
<p>Orthopedic braces and prosthetic appliances such as:</p> <ul style="list-style-type: none"> • Artificial limbs and eyes • Functional foot orthotics when prescribed by a physician • Rigid devices attached to the foot or a brace, or placed in a shoe • Replacement, repair, and adjustment of covered devices • Following a mastectomy, breast prostheses and surgical bras, including necessary replacements <p>Note: A prosthetic appliance is a device that is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body.</p> <p>We provide hospital benefits for internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b).</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Shoes and over-the-counter orthotics</i> • <i>Arch supports</i> • <i>Heel pads and heel cups</i> • <i>Penile implants</i> • <i>Wigs (including cranial prostheses)</i> • <i>Implanted bone conduction hearing aids</i> 	<i>All charges</i>	<i>All charges</i>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Durable medical equipment (DME)	You Pay – Standard Option	You Pay – Basic Option
<p>Durable medical equipment (DME) is equipment and supplies that:</p> <ol style="list-style-type: none"> 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. <p>We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment. Under this benefit, we cover:</p> <ul style="list-style-type: none"> • Home dialysis equipment • Oxygen equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Continuous passive motion (CPM) and dynamic orthotic cranioplasty (DOC) devices • Other items that we determine to be DME, such as compression stockings <p>Note: We cover DME at Preferred benefit levels only when you use a Preferred DME provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred DME providers.</p> <p>Note: See Section 5(c) for our coverage of DME provided and billed by a facility.</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Exercise and bathroom equipment</i> • <i>Lifts, such as seat, chair, or van lifts</i> • <i>Car seats</i> • <i>Air conditioners, humidifiers, dehumidifiers, and purifiers</i> • <i>Breast pumps</i> • <i>Computer equipment/devices such as “story boards” or other communication aids to assist communication-impaired individuals</i> • <i>Equipment for cosmetic purposes</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Medical supplies	You Pay – Standard Option	You Pay – Basic Option
<ul style="list-style-type: none"> • Medical foods for children with inborn errors of amino acid metabolism • Medical foods and nutritional supplements when administered by catheter or nasogastric tubes • Ostomy and catheter supplies • Oxygen, regardless of the provider • Blood and blood plasma except when donated or replaced, and blood plasma expanders <p><i>Note:</i> We cover medical supplies at Preferred benefit levels only when you use a Preferred medical supply provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred medical supply providers.</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Non-participating: You pay all charges</p>
Home health services		
<p>Home nursing care for two (2) hours per day, up to 25 visits per calendar year, when:</p> <ul style="list-style-type: none"> • A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and • A physician orders the care 	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p><i>Note:</i> Visits that you pay for while meeting your calendar year deductible count toward the annual visit limit.</p>	<p>Preferred: \$20 copayment per visit</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Services primarily for bathing, feeding, exercising, moving the patient, homemaking, giving medication, or acting as a companion or sitter</i> 	<i>All charges</i>	<i>All charges</i>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Chiropractic	You Pay – Standard Option	You Pay – Basic Option
<ul style="list-style-type: none"> • Initial office visit • Spinal manipulations • Initial set of X-rays 	<p><i>All charges</i></p> <p>Note: Benefits may be available for covered services you receive from chiropractors in medically underserved areas. See page 11 for additional information.</p>	<p>Preferred: \$20 copayment per visit, up to 20 manipulations per calendar year</p> <p>Participating/Non-participating: You pay all charges</p>
Alternative treatments		
<p>Acupuncture – when performed and billed by a physician for:</p> <ul style="list-style-type: none"> • pain relief, and • as a modality of physical therapy <p>Note: See page 37 for limitations.</p> <p>Note: We may also cover services of certain alternative treatment providers in medically underserved areas. See page 11 for additional information.</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services you receive from noncovered providers such as:</i> <ul style="list-style-type: none"> – <i>naturopaths</i> – <i>hypnotherapists</i> • <i>Biofeedback (or other forms of self-care or self-help training)</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Educational classes and programs	You Pay – Standard Option	You Pay – Basic Option
<ul style="list-style-type: none"> • Smoking cessation <p><i>Note:</i> See Section 5(e) for our coverage of individual and group psychotherapy for smoking cessation and Section 5(f) for our coverage of smoking cessation drugs.</p>	<p>Preferred: \$15 copayment for the office visit charge (No deductible); 10% of the Plan allowance for all other services (deductible applies)</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Participating/Non-participating: You pay all charges</p>
<ul style="list-style-type: none"> • Diabetic education when billed by a covered provider <p><i>Note:</i> We cover diabetic educators, dieticians, and nutritionists who bill independently only as part of a covered diabetic education program.</p> <ul style="list-style-type: none"> • Nutritional counseling when billed by a covered provider for anorexia and bulimia <p><i>Note:</i> We cover dieticians and nutritionists who bill independently for the treatment of anorexia and bulimia.</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Marital, family, educational, or other counseling or training services when performed as part of an educational class or program • Premenstrual syndrome (PMS), lactation, headache, eating disorder (except as described above), and other educational clinics • Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay • Services performed or billed by a school or halfway house or a member of its staff 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

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

Here are some 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.
- **Under Standard Option**, the calendar year deductible is \$250 per person (\$500 per family). The calendar year deductible applies to almost all **Standard Option** benefits in this Section. We say “(No deductible)” to show when the calendar year deductible does not apply.
- **Under Standard Option**, we provide benefits at 90% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician’s office). You are responsible for any difference between our allowance and the billed amount.
- **Under Basic Option**, there is **no calendar year deductible**.
- **Under Basic Option**, you must use Preferred providers in order to receive benefits. See below and page 12 for the exceptions to this requirement.
- **Under Basic Option**, we provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician’s office). You are responsible for any difference between our allowance and the billed amount.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service.
- The amounts listed in this section are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL for all organ transplant surgical procedures (except kidney and cornea transplants); and if your surgical procedure requires an inpatient admission, YOU MUST GET PRECERTIFICATION. Please refer to the prior approval and precertification information shown in Section 3 to be sure which services require prior approval or precertification.**
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

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Benefit Description	You Pay	
<p>Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does <i>not</i> apply. There is no calendar year deductible under Basic Option.</p>		
Surgical procedures	You Pay – Standard Option	You Pay – Basic Option
<p>A comprehensive range of services provided, or ordered and billed by a physician, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures and dislocations, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Colonoscopy – screening or diagnostic • Other endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery on page 48) • Treatment of burns • Circumcision of newborn • Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic devices, and Section 5(c) – Other hospital services and supplies – for our coverage for the device. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Assistant surgeons/surgical assistance by a physician if required because of the complexity of the surgical procedures • Gastric bypass surgery or gastric stapling procedures for morbid obesity – a condition in which an individual weighs 100 pounds over, or 100% over, his or her normal weight according to current underwriting standards; eligible members must be age 18 or over 	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$100 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$100 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Surgical procedures (continued)	You Pay – Standard Option	You Pay – Basic Option
<p><i>Note:</i> When multiple surgical procedures that add time or complexity to patient care are performed during the same operative session, the Local Plan determines our allowance for the combination of multiple, bilateral, or incidental surgical procedures. Generally, we will allow a reduced amount for procedures other than the primary procedure.</p> <p><i>Note:</i> We do not pay extra for “incidental” procedures (those that do not add time or complexity to patient care).</p> <p><i>Note:</i> When unusual circumstances require the removal of casts or sutures by a physician other than the one who applied them, the Local Plan may determine that a separate allowance is payable.</p>		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Services of a standby physician</i> • <i>Routine surgical treatment of conditions of the foot [see Section 5(a) – Foot care]</i> • <i>Cosmetic surgery</i> • <i>LASIK, radial keratotomy, and other refractive surgery</i> 	<i>All charges</i>	<i>All charges</i>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Reconstructive surgery	You Pay – Standard Option	You Pay – Basic Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a congenital anomaly – a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. <p><i>Note:</i> Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth.</p> <ul style="list-style-type: none"> • Treatment to restore the mouth to a pre-cancer state • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – surgery to produce a symmetrical appearance of the patient’s breasts – treatment of any physical complications, such as lymphedemas <p><i>Note:</i> Internal breast prostheses are paid as orthopedic and prosthetic devices [see Section 5(a)]. See Section 5(c) when billed by a facility.</p> <p><i>Note:</i> If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$100 copayment per performing surgeon</p> <p><i>Note:</i> If you receive the services of a co-surgeon, you pay a second \$100 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any operative procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form – unless required for a congenital anomaly or to restore or correct a part of the body that has been altered as a result of accidental injury, disease, or surgery (does not include anomalies related to the teeth or structures supporting the teeth)</i> • <i>Surgeries related to sex transformation, sexual dysfunction, or sexual inadequacy</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Oral and maxillofacial surgery	You Pay – Standard Option	You Pay – Basic Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is necessary • Surgery needed to correct accidental injuries (see Definitions) to jaws, cheeks, lips, tongue, roof and floor of mouth • Excision of exostoses of jaws and hard palate • Incision and drainage of abscesses and cellulitis • Incision and surgical treatment of accessory sinuses, salivary glands, or ducts • Reduction of dislocations and excision of temporomandibular joints • Removal of impacted teeth 	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$100 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$100 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Surgical procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), except as shown above and in Section 5(h)</i> • <i>Surgical procedures involving orthodontic care, dental implants, or preparation of the mouth for the fitting or the continued use of dentures, except as specifically shown above and in Section 5(h)</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Organ/tissue transplants	You Pay – Standard Option	You Pay – Basic Option
<ul style="list-style-type: none"> • Cornea • Heart • Heart-lung • Kidney • Liver • Pancreas • Single or double lung: only for the following end-stage pulmonary diseases: pulmonary fibrosis, primary pulmonary hypertension, and emphysema • Double lung: only for patients with end-stage cystic fibrosis • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas 	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$100 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$100 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>
<p>Bone marrow and stem cell transplants, limited to:</p> <ul style="list-style-type: none"> • Allogeneic bone marrow transplants and allogeneic cord blood stem cell transplants (from related or unrelated donors) for: <ul style="list-style-type: none"> – Advanced neuroblastoma – Infantile malignant osteopetrosis – Severe combined immunodeficiency – Mucopolysaccharidosis (e.g., Hunter, Hurler’s, Sanfilippo, Maroteaux-Lamy variants) – Mucopolysaccharidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) – Severe or very severe aplastic anemia – Thalassemia major (homozygous beta-thalassemia) – Sickle cell anemia – Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) 	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$100 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$100 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants – *continued on next page*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Organ/tissue transplants (continued)	You Pay – Standard Option	You Pay – Basic Option
<p>Bone marrow and stem cell transplants, limited to: <i>(continued)</i></p> <ul style="list-style-type: none"> • Allogeneic bone marrow transplants, allogeneic cord blood stem cell transplants (from related or unrelated donors) and allogeneic peripheral blood stem cell transplants for: <ul style="list-style-type: none"> – Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia – Advanced Hodgkin’s lymphoma – Advanced non-Hodgkin’s lymphoma – Chronic myelogenous leukemia – Advanced forms of myelodysplastic syndromes • Autologous bone marrow transplants and autologous peripheral blood stem cell transplants (collectively referred to as autologous stem cell support) for: <ul style="list-style-type: none"> – Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia – Advanced Hodgkin’s lymphoma – Advanced non-Hodgkin’s lymphoma – Advanced neuroblastoma – Amyloidosis – Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors – Multiple myeloma 	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$100 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$100 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants – *continued on next page*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Organ/tissue transplants (continued)	You Pay – Standard Option	You Pay – Basic Option
<ul style="list-style-type: none"> • Extraction or reinfusion of bone marrow, blood stem cells, or cord blood as a source of stem cells as part of a covered allogeneic or autologous bone marrow transplant or blood stem cell transplant support procedure • Marrow harvesting in anticipation of a covered autologous bone marrow transplant, for patients diagnosed at the time of harvesting with one of the conditions listed on page 51, 54, or 55 • Collection, processing, storage, and distribution of cord blood • Storage of harvested bone marrow, blood stem cells, or cord blood as a source of stem cells, only when a covered transplant has already been scheduled • Related medical and hospital expenses of the donor, as part of a covered transplant procedure • Related services or supplies provided to the recipient <p><i>Note:</i> See Section 5(a) for coverage for related services, such as chemotherapy and/or radiation therapy and drugs administered to stimulate or mobilize stem cells for covered transplant procedures.</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$100 copayment per performing surgeon</p> <p><i>Note:</i> If you receive the services of a co-surgeon, you pay a second \$100 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants – *continued on next page*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Organ/tissue transplants (continued)

Organ/Tissue Transplants at Blue Quality Centers for Transplant (BQCT)

We participate in the Blue Quality Centers for Transplant (BQCT), a centers of excellence program for the organ/tissue transplants listed below. You will receive enhanced benefits if you use a BQCT facility.

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

- Heart
- Heart-lung
- Liver
- Pancreas
- Simultaneous pancreas-kidney
- Single or double lung: only for the following end-stage pulmonary diseases: pulmonary fibrosis, primary pulmonary hypertension, and emphysema
- Double lung: only available for patients with end-stage cystic fibrosis
- Bone marrow and stem cell transplants listed on pages 50, 51, 54, and 55
- Related transplant services listed on page 52

Note: Benefits for cornea, kidney-only, and intestinal transplants are not available through BQCT. See page 50 for benefit information for these transplants.

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

Note: Members will not be responsible for separate cost-sharing for the included professional services (see page 12).

Note: See below and pages 54 and 55 for limitations to bone marrow and stem cell transplant coverage.

Note: See page 12 for special instructions regarding all admissions to BQCT institutions.

Organ/tissue transplants (continued)	You Pay – Standard Option	You Pay – Basic Option
<p>Limitations for all transplants</p> <p>(1) You must obtain prior approval (see page 15) from the Local Plan, for both the procedure and the facility, for the following transplant procedures:</p> <ul style="list-style-type: none"> • Bone marrow, cord blood stem cell, and peripheral blood stem cell transplant support procedures • Heart • Heart-lung • Liver • Lung (single/double) • Pancreas • Simultaneous pancreas-kidney • Intestinal transplants (small intestine with or without other organs) 		

Organ/tissue transplants – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Organ/tissue transplants (continued)	You Pay – Standard Option	You Pay – Basic Option
<p>(2) For the following procedures, we provide benefits only when conducted at a Cancer Research Facility (see page 12) and performed as part of a clinical trial that meets the requirements shown below:</p> <ul style="list-style-type: none"> • Allogeneic bone marrow transplants, syngeneic bone marrow transplants, and allogeneic peripheral blood stem cell transplants for: <ul style="list-style-type: none"> – Multiple myeloma – Chronic lymphocytic leukemia – Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Nonmyeloablative allogeneic stem cell transplants for: <ul style="list-style-type: none"> – Chronic myelogenous leukemia – Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia – Advanced Hodgkin’s lymphoma – Advanced non-Hodgkin’s lymphoma – Advanced forms of myelodysplastic syndromes – Multiple myeloma – Chronic lymphocytic leukemia – Early stage (indolent or non-advanced) small cell lymphocytic lymphoma – Renal cell carcinoma • Autologous bone marrow transplants and autologous peripheral blood stem cell transplants (collectively referred to as autologous stem cell support) for: <ul style="list-style-type: none"> – Breast cancer – Epithelial ovarian cancer – Chronic myelogenous leukemia – Chronic lymphocytic leukemia – Early stage (indolent or non-advanced) small cell lymphocytic lymphoma 	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$100 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$100 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>

Organ/tissue transplants – continued on next page

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Organ/tissue transplants (continued)	You Pay – Standard Option	You Pay – Basic Option
<ul style="list-style-type: none"> • Autologous bone marrow or peripheral blood stem cell transplants when performed in specific NIH-funded, randomized, multi-center, comparative trials for the following autoimmune diseases: <ul style="list-style-type: none"> – Systemic sclerosis – Systemic lupus erythematosus – Multiple sclerosis <p>For these bone marrow transplant procedures and related services or supplies covered only through clinical trials:</p> <ol style="list-style-type: none"> 1. You must contact our Clinical Trials Information Unit at 1-800-225-2268 for prior approval (see page 15); 2. The clinical trial must be reviewed and approved by the Institutional Review Board of the Cancer Research Facility where the procedure is to be delivered; and 3. The patient must be properly and lawfully registered in the clinical trial, meeting all the eligibility requirements of the trial. <p>If a non-randomized clinical trial meeting these requirements is not available at a Cancer Research Facility where you are eligible, we will arrange for the transplant to be provided at another Plan-designated transplant facility.</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$100 copayment per performing surgeon</p> <p>Note: If you receive the services of a co-surgeon, you pay a second \$100 copayment for those services. No additional copayment applies to the services of assistant surgeons.</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Transplants for any diagnosis not listed as covered</i> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Anesthesia	You Pay – Standard Option	You Pay – Basic Option
<p>Anesthesia (including acupuncture) for covered surgical services when requested by the attending physician and performed by:</p> <ul style="list-style-type: none"> • a certified registered nurse anesthetist (CRNA), or • a physician other than the operating physician (surgeon) or the assistant <p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office <p>Anesthesia services consist of administration by injection or inhalation of a drug or other anesthetic agent (including acupuncture) to obtain muscular relaxation, loss of sensation, or loss of consciousness.</p> <p>Note: See Section 5(c) for our payment levels for anesthesia services billed by a facility.</p>	<p>Preferred: 10% of the Plan allowance</p> <p>Participating: 25% of the Plan allowance</p> <p>Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: Nothing</p> <p>Participating/Non-participating: You pay all charges</p>

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

Here are some important things you should keep in mind about these benefits:

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this section, unlike Sections 5(a) and 5(b), the **Standard Option** calendar year deductible applies to only a few benefits. In that case, we added “(calendar year deductible applies)” when it applies. The calendar year deductible is \$250 per person (\$500 per family) under Standard Option.
- **Under Basic Option, there is no calendar year deductible.**
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See page 12 for the exceptions to this requirement.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY.** Please refer to the precertification information listed in Section 3 to be sure which services require precertification.
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.
- The amounts listed in this section are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your inpatient surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are listed in Sections 5(a) or 5(b).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

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Benefit Description	You Pay	
<p>Note: The Standard Option calendar year deductible applies ONLY when we say below: “(calendar year deductible applies).” There is no calendar year deductible under Basic Option.</p>		
Inpatient hospital	You Pay – Standard Option	You Pay – Basic Option
<p>Room and board, such as:</p> <ul style="list-style-type: none"> • semiprivate or intensive care accommodations • general nursing care • meals and special diets <p>Note: We cover a private room only when you must be isolated to prevent contagion, when your isolation is required by law, or when a Preferred or Member hospital only has private rooms. Otherwise, we will pay the hospital’s average semiprivate rate as determined by the Local Plan. If a Non-member hospital only has private rooms, we base our payment on the average semiprivate rate as determined by the Local Plan.</p>	<p>Preferred: \$100 per admission copayment for unlimited days</p> <p>Member: \$300 per admission copayment for unlimited days</p> <p>Non-member: \$300 per admission copayment for unlimited days, plus 30% of the Plan allowance, and any remaining balance after our payment</p> <p>Note: If you are admitted to a Non-member facility due to a medical emergency or accidental injury, you pay a \$300 per admission copayment for unlimited days and we then provide benefits at 100% of the Plan allowance. You are responsible for any remaining balance after our payment.</p>	<p>Preferred: \$100 per day copayment up to \$500 per admission for unlimited days</p> <p>Member/Non-member: You pay all charges</p>

Inpatient hospital – *continued on next page*

Note: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.

Inpatient hospital (continued)	You Pay – Standard Option	You Pay – Basic Option
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs • Diagnostic laboratory tests, pathology services, MRIs, machine diagnostic tests, and X-rays • Administration of blood or blood plasma • Dressings, splints, casts, and sterile tray services • Internal prosthetic devices • Other medical supplies and equipment, including oxygen • Anesthetics and anesthesia services • Take-home items • Pre-admission testing recognized as part of the hospital admissions process • Nutritional counseling <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 14 for other circumstances, such as extended stays for you or your baby. • If you need to stay longer in the hospital than initially planned, we will cover an extended stay if it is medically necessary. However, you must precertify the extended stay. See Section 3 for information on requesting additional days. • We pay inpatient hospital benefits for an admission in connection with dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. We provide benefits for dental procedures as shown in Section 5(h). <p>Note: See pages 32-33 for covered maternity services.</p> <p>Note: See page 42 for coverage of blood and blood products.</p>	<p>Preferred: \$100 per admission copayment for unlimited days</p> <p>Member: \$300 per admission copayment for unlimited days</p> <p>Non-member: \$300 per admission copayment for unlimited days, plus 30% of the Plan allowance, and any remaining balance after our payment</p>	<p>Preferred: \$100 per day copayment up to \$500 per admission for unlimited days</p> <p>Member/Non-member: You pay all charges</p>

Inpatient hospital – continued on next page

Note: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.

Inpatient hospital (continued)	You Pay – Standard Option	You Pay – Basic Option
<p><i>Not covered:</i></p> <p><i>Hospital room and board expenses when, in our judgement, a hospital admission or portion of an admission is:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Convalescent care or a rest cure</i> • <i>Domiciliary care provided because care in the home is not available or unsuitable</i> • <i>Not medically necessary, such as when services did not require the acute/subacute hospital inpatient (overnight) setting but could have been provided safely and adequately in a physician's office, the outpatient department of a hospital, or some other setting, without adversely affecting your condition or the quality of medical care you receive. Some examples are:</i> <ul style="list-style-type: none"> – <i>Admissions for, or consisting primarily of, observation and/or evaluation that could have been provided safely and adequately in some other setting (such as a physician's office)</i> – <i>Admissions primarily for diagnostic studies, laboratory and pathology services, X-rays, MRIs, or machine diagnostic tests that could have been provided safely and adequately in some other setting (such as the outpatient department of a hospital or a physician's office)</i> <p>Note: <i>If we determine that a hospital admission is one of the types listed above, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.</i></p> <ul style="list-style-type: none"> • <i>Admission to noncovered facilities, such as nursing homes, extended care facilities, schools, residential treatment centers</i> • <i>Personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services</i> • <i>Inpatient private duty nursing</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Note: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)." **There is no calendar year deductible under Basic Option.**

Outpatient hospital or ambulatory surgical center	You Pay – Standard Option	You Pay – Basic Option
<p>Outpatient medical services performed and billed for by a hospital or freestanding ambulatory facility, such as:</p> <ul style="list-style-type: none"> • Use of special treatment rooms • Diagnostic tests, such as laboratory and pathology services, MRIs, machine diagnostic tests, and X-rays • Chemotherapy and radiation therapy • Intravenous (IV)/infusion therapy • Cardiac rehabilitation • Physical, occupational, and speech therapy • Renal dialysis • Visits to the outpatient department of a hospital for non-emergency medical care • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced, and other biologicals • Dressings, splints, casts, and sterile tray services • Other medical supplies, including oxygen <p><i>Note:</i> See pages 29-31 for covered preventive services for adults and children.</p> <p><i>Note:</i> See pages 67-71 for our payment levels for care related to a medical emergency or accidental injury.</p>	<p>Preferred facilities: 10% of the Plan allowance (calendar year deductible applies)</p> <p>Member facilities: 25% of the Plan allowance (calendar year deductible applies)</p> <p>Non-member facilities: 25% of the Plan allowance (calendar year deductible applies)</p> <p><i>Note:</i> See page 37 for our coverage of physical, occupational, and speech therapy.</p>	<p>Preferred: \$40 copayment per day per facility</p> <p>Member/Non-member: You pay all charges</p> <p><i>Note:</i> For outpatient diagnostic tests billed for by a Member or Non-member facility, you pay a \$40 copayment.</p>

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

Note: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.

Outpatient hospital or ambulatory surgical center <i>(continued)</i>	You Pay – Standard Option	You Pay – Basic Option
<p>Outpatient surgery and related services performed and billed for by a hospital or freestanding ambulatory facility, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Anesthetics and anesthesia services • Pre-surgical testing performed within one business day of the covered surgical services • Facility supplies for hemophilia home care • Diagnostic tests, such as laboratory and pathology services, MRIs, machine diagnostic tests, and X-rays • Visits to the outpatient department of a hospital for non-emergency surgical care • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced, and other biologicals • Dressings, splints, casts, and sterile tray services • Other medical supplies, including oxygen <p><i>Note:</i> See pages 67-71 for our payment levels for care related to a medical emergency or accidental injury.</p> <p><i>Note:</i> We cover outpatient hospital services and supplies related to dental procedures only when a non-dental physical impairment exists that makes the hospital setting necessary to safeguard the health of the patient. See Section 5(h), <i>Dental benefits</i>, for additional benefit information.</p> <p><i>Note:</i> See pages 32-33 for covered maternity services.</p>	<p>Preferred facilities: 10% of the Plan allowance</p> <p>Member facilities: 25% of the Plan allowance</p> <p>Non-member facilities: 25% of the Plan allowance</p>	<p>Preferred: \$40 copayment per day per facility</p> <p>Member/Non-member: You pay all charges</p> <p><i>Note:</i> For outpatient diagnostic tests billed for by a Member or Non-member facility, you pay a \$40 copayment.</p>

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

Note: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)." **There is no calendar year deductible under Basic Option.**

Outpatient hospital or ambulatory surgical center (<i>continued</i>)	You Pay – Standard Option	You Pay – Basic Option
<p>Outpatient drugs, medical devices, and durable medical equipment billed for by a hospital or freestanding ambulatory facility, such as:</p> <ul style="list-style-type: none"> • Prescribed drugs • Orthopedic and prosthetic devices • Durable medical equipment 	<p>Preferred facilities: 10% of the Plan allowance (calendar year deductible applies)</p> <p>Member facilities: 25% of the Plan allowance (calendar year deductible applies)</p> <p>Non-member facilities: 25% of the Plan allowance (calendar year deductible applies)</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Note: You may also be responsible for paying a \$40 copayment per day per facility for outpatient services.</p> <p>Member/Non-member: You pay all charges</p>

Note: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.

Extended care benefits/Skilled nursing care facility benefits	You Pay – Standard Option	You Pay – Basic Option
<p>Limited to the following benefits for Medicare Part A copayments:</p> <p>When Medicare Part A is the primary payer (meaning that it pays first) and has made payment, Standard Option provides limited secondary benefits.</p> <p>We pay the applicable Medicare Part A copayments incurred in full during the first through the 30th day of confinement for each benefit period (as defined by Medicare) in a qualified skilled nursing facility. A qualified skilled nursing facility is a facility that specializes in skilled nursing care performed by or under the supervision of licensed nurses, skilled rehabilitation services, and other related care, and meets Medicare’s special qualifying criteria, but is not an institution that primarily cares for and treats mental diseases.</p> <p>If Medicare pays the first 20 days in full, Plan benefits will begin on the 21st day (when Medicare Part A copayments begin) and will end on the 30th day.</p> <p>Note: See page 37 for benefits provided for outpatient physical, occupational, and speech therapy when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs.</p> <p>Note: If you do not have Medicare Part A, we do not provide benefits for skilled nursing facility care.</p>	<p>Preferred: Nothing</p> <p>Participating/Member: Nothing</p> <p>Non-participating/Non-member: Nothing</p> <p>Note: You pay all charges not paid by Medicare after the 30th day.</p>	<p><i>All charges</i></p>

Note: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.

Hospice care	You Pay – Standard Option	You Pay – Basic Option
<p>Hospice care is an integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients in their homes.</p> <p>We provide the following home hospice care benefits for members with a life expectancy of six months or less when prior approval is obtained from the Local Plan and the home hospice agency is approved by the Local Plan:</p> <ul style="list-style-type: none"> • Physician visits • Nursing care • Medical social services • Physical therapy • Services of home health aides • Durable medical equipment rental • Prescription drugs • Medical supplies 	<p>Nothing</p>	<p>Nothing</p>
<p>Inpatient hospice for members receiving home hospice care benefits:</p> <p>Benefits are provided for up to five (5) consecutive days in a hospital or a freestanding hospice inpatient facility.</p> <p>Each inpatient stay must be separated by at least 21 days.</p> <p>These covered inpatient hospice benefits are available only when inpatient services are necessary to:</p> <ul style="list-style-type: none"> • control pain and manage the patient’s symptoms; or • provide an interval of relief (respite) to the family <p>Note: You are responsible for making sure that the home hospice care provider has received prior approval from the Local Plan (see page 14 for instructions). Please check with your Local Plan and/or your PPO directory for listings of approved agencies.</p>	<p>Preferred: \$100 per admission copayment</p> <p>Member: \$300 per admission copayment</p> <p>Non-member: \$300 per admission copayment plus 30% of the Plan allowance, and any remaining balance after our payment</p>	<p>Preferred: \$100 per day copayment up to \$500 per admission</p> <p>Member/Non-member: You pay all charges</p>
<p><i>Not covered: Homemaker or bereavement services</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Note: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)." There is no calendar year deductible under Basic Option.

Ambulance	You Pay – Standard Option	You Pay – Basic Option
<p>Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and:</p> <ul style="list-style-type: none"> • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care 	<p>Preferred: 10% of the Plan allowance</p> <p>Participating/Member: 10% of the Plan allowance</p> <p>Non-participating/Non-member: 10% of the Plan allowance, plus any difference between our allowance and the billed amount</p>	<p>Preferred: \$50 copayment per trip</p> <p>Participating/Member or Non-participating/Non-member: \$50 copayment per trip</p>
<p>Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating/Member: Nothing (No deductible)</p> <p>Non-participating/Non-member: Any difference between the Plan allowance and the billed amount (No deductible)</p> <p>Note: These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.</p>	<p>Preferred: \$50 copayment per trip</p> <p>Participating/Member or Non-participating/Non-member: \$50 copayment per trip</p>

Section 5(d) Emergency services/accidents

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Here are some 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.
- **Under Standard Option**, the calendar year deductible is \$250 per person (\$500 per family). The calendar year deductible applies to almost all **Standard Option** benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under Basic Option**, there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits, except in cases of medical emergency or accidental injury. Refer to the guidelines appearing below for additional information.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

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What is an accidental injury?

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

What is a medical emergency?

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

Basic Option benefits for emergency care

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

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

Benefit Description	You Pay	
<p>Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say “(No deductible)” when the Standard Option deductible does <i>not</i> apply. There is no calendar year deductible under Basic Option.</p>		
Accidental injury	You Pay – Standard Option	You Pay – Basic Option
<ul style="list-style-type: none"> • Physician services in the hospital outpatient department, urgent care center, or physician’s office, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests • Related outpatient hospital services and supplies, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests <p>Note: We pay Inpatient professional and hospital benefits if you are admitted [see Sections 5(a), 5(b), and 5(c)].</p> <p>Note: See Section 5(h) for dental benefits for accidental injuries.</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating/Member: Nothing (No deductible)</p> <p>Non-participating/Non-member: Any difference between the Plan allowance and the billed amount (No deductible)</p> <p>Note: These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, regular medical and outpatient hospital benefits apply. See Section 5(a), Medical services and supplies, Section 5(b), Surgical procedures, and Section 5(c), Outpatient hospital, for the benefits we provide.</p>	<p>Preferred emergency room: \$50 copayment per visit</p> <p>Participating/Member emergency room: \$50 copayment per visit</p> <p>Non-participating/Non-member emergency room: \$50 copayment per visit</p> <p>Note: You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount.</p> <p>Note: If you are admitted directly to the hospital from the emergency room, you do not have to pay the \$50 emergency room copayment. However, the \$100 per day copayment for Preferred inpatient care still applies.</p> <p>Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.</p>

Accidental injury – *continued on next page*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Accidental injury (<i>continued</i>)	You Pay – Standard Option	You Pay – Basic Option
		<p>For the following places of service, you must receive care from a Preferred provider:</p> <p>Preferred urgent care center: \$30 copayment per visit</p> <p>Preferred primary care provider or other health care professional’s office: \$20 copayment per visit</p> <p>Preferred specialist’s office: \$30 copayment per visit</p> <p>Participating/Member (for other than emergency room): You pay all charges</p> <p>Non-participating/Non-member (for other than emergency room): You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Oral surgery except as shown in Section 5(b) • Injury to the teeth while eating 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Medical emergency	You Pay – Standard Option	You pay – Basic Option
<ul style="list-style-type: none"> • Physician services in the hospital outpatient department, urgent care center, or physician’s office, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests • Related outpatient hospital services and supplies, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests <p><i>Note:</i> We pay Inpatient professional and hospital benefits if you are admitted as a result of a medical emergency [see Sections 5(a), 5(b), and 5(c)].</p> <p><i>Note:</i> Please refer to Section 3 for information about precertifying emergency hospital admissions.</p>	<p>Preferred: 10% of the Plan allowance</p> <p><i>Note:</i> If you receive services in a Preferred physician’s office, you pay a \$15 copayment (No deductible) for the office visit, and 10% of the Plan allowance for all other services (deductible applies).</p> <p>Participating/Member: 25% of the Plan allowance</p> <p>Non-participating/Non-member: 25% of the Plan allowance, plus any difference between our allowance and the billed amount</p> <p><i>Note:</i> These benefit levels do not apply if you receive care in connection with, and within 72 hours after, an accidental injury. See Accidental Injury benefits on pages 67-69 for the benefits we provide.</p>	<p>Preferred emergency room: \$50 copayment per visit</p> <p>Participating/Member emergency room: \$50 copayment per visit</p> <p>Non-participating/Non-member emergency room: \$50 copayment per visit</p> <p><i>Note:</i> You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount.</p> <p><i>Note:</i> If you are admitted directly to the hospital from the emergency room, you do not have to pay the \$50 emergency room copayment. However, the \$100 per day copayment for Preferred inpatient care still applies.</p> <p><i>Note:</i> All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.</p> <p>For the following places of service, you must receive care from a Preferred provider:</p> <p>Preferred urgent care center: \$30 copayment per visit</p> <p>Preferred primary care provider or other health care professional’s office: \$20 copayment per visit</p> <p>Preferred specialist’s office: \$30 copayment per visit</p> <p>Participating/Member (for other than emergency room): You pay all charges</p> <p>Non-participating/Non-member (for other than emergency room): You pay all charges</p>

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Ambulance	You Pay – Standard Option	You pay – Basic Option
<p>Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and:</p> <ul style="list-style-type: none"> • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care <p><i>Note:</i> See Section 5(c) for non-emergency ambulance services.</p>	<p>Preferred: 10% of the Plan allowance (No deductible)</p> <p>Participating/Member: 10% of the Plan allowance (No deductible)</p> <p>Non-participating/Non-member: 10% of the Plan allowance, plus any difference between our allowance and the billed amount (No deductible)</p>	<p>Preferred: \$50 copayment per trip</p> <p>Participating/Member or Non-participating/Non-member: \$50 copayment per trip</p>
<p>Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and when related to accidental injury</p>	<p>Preferred: Nothing (No deductible)</p> <p>Participating/Member: Nothing (No deductible)</p> <p>Non-participating/Non-member: Any difference between the Plan allowance and the billed amount (No deductible)</p> <p><i>Note:</i> These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.</p>	<p>Preferred: \$50 copayment per trip</p> <p>Participating/Member or Non-participating/Non-member: \$50 copayment per trip</p>

Section 5(e) Mental health and substance abuse benefits

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Here are some 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.
- Under **Standard Option**, the calendar year deductible or, for facility care, the inpatient per admission copay, applies to almost all benefits in this Section. We added “(No deductible)” to show when the deductible does not apply.
- **Under Standard Option**, there is a maximum of 25 visits per year for office visits, partial hospitalization, intensive outpatient treatment, and other hospital outpatient treatment. The first 25 visits under Standard Option each calendar year by Preferred providers and Non-preferred providers count toward this maximum. This maximum may be waived for services received from Preferred providers.
- Under **Standard Option**, you may choose to get care In-Network (Preferred) or Out-of-Network (Non-preferred). When you use a Preferred provider, he or she must submit a treatment plan to us **prior to your ninth outpatient visit** in order to maximize the benefits you receive. Preferred benefits are payable when the care is clinically appropriate to treat your condition and when you receive the care as part of a treatment plan that we approve. Cost-sharing and limitations for In-Network (Preferred) mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.
- **Under Basic Option, you must call us for prior approval before receiving care.** We will provide you with the names and phone numbers of several Preferred providers and tell you how many visits we are initially approving. You may then choose which of those providers you would like to see. **You must use Preferred providers in order to receive Basic Option benefits.**
- **Under Basic Option**, there is **no calendar year deductible**.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY.** Please refer to the precertification information listed in Section 3. Some other services also require prior approval. See the instructions after the benefits descriptions below.
- **Standard Option and Basic Option benefits** for Preferred (In-Network) mental health and substance abuse care begin below and are continued on the following pages. Standard Option benefits for Non-preferred (Out-of-Network) care begin on page 76.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Benefit Description	You Pay	
<p>Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say “(No deductible)” when the Standard Option deductible does <i>not</i> apply.</p> <p>There is no calendar year deductible under Basic Option.</p>		
Preferred (In-Network) benefits	You Pay – Standard Option	You Pay – Basic Option
<p>All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p><i>Note:</i> Preferred benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care from a Preferred provider as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>

Preferred (In-Network) benefits – *continued on next page*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say “(No deductible)” when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Preferred (In-Network) benefits <i>(continued)</i>	You Pay – Standard Option	You Pay – Basic Option
<p>Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, clinical social workers, or psychiatric nurses</p> <ul style="list-style-type: none"> • Office and home visits • In a hospital outpatient department (except for emergency rooms) • Psychotherapy for smoking cessation <p>Note: Additional types of licensed providers may be available to you for mental health and substance abuse services. Consult your PPO directory or contact your Local Plan at the mental health and substance abuse phone number on the back of your ID card.</p>	<p>\$15 copayment for the visit, up to two hours per visit (No deductible)</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay a \$40 copayment for outpatient services billed for by a facility.</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p>
<ul style="list-style-type: none"> • Pharmacotherapy (medication management) • Psychological testing (not subject to the two-hour limit) 	<p>Preferred: \$15 copayment for the office visit charge (No deductible)</p>	<p>Preferred primary care provider or other health care professional: \$20 copayment per visit</p> <p>Preferred specialist: \$30 copayment per visit</p> <p>Note: You pay 30% of the Plan allowance for drugs and supplies.</p>
<ul style="list-style-type: none"> • Inpatient professional visits • Professional charges for facility-based intensive outpatient treatment 	<p>10% of the Plan allowance</p> <p>Note: Intensive outpatient treatment is not limited to two hours per visit but you must obtain prior approval.</p>	<p>Nothing</p>
<ul style="list-style-type: none"> • Professional charges for intensive outpatient treatment in a provider’s office or other professional setting 	<p>10% of the Plan allowance</p> <p>Note: Intensive outpatient treatment is not limited to two hours per visit but you must obtain prior approval.</p>	<p>Preferred: \$30 copayment per visit</p>
<ul style="list-style-type: none"> • Professional charges for outpatient diagnostic tests 	<p>10% of the Plan allowance</p>	<p>Nothing</p>

Preferred (In-Network) benefits – *continued on next page*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Preferred (In-Network) benefits <i>(continued)</i>	You Pay – Standard Option	You Pay – Basic Option
Inpatient services provided and billed by a hospital or other covered facility <ul style="list-style-type: none"> • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Diagnostic tests Note: You must get precertification of inpatient hospital stays; failure to do so will result in a \$500 penalty.	\$100 per admission copayment (No deductible)	\$100 per day copayment up to \$500 per admission
Outpatient services provided and billed by a hospital or other covered facility <ul style="list-style-type: none"> • Diagnostic tests • Services in the following approved treatment programs (must be prior approved): <ul style="list-style-type: none"> – partial hospitalization – facility-based intensive outpatient treatment 	10% of the Plan allowance	\$40 copayment per day per facility Note: You pay 30% of the Plan allowance for drugs.
<i>Not covered:</i> <ul style="list-style-type: none"> • Services we have not approved • Educational or training services • Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present 	<i>All charges</i>	<i>All charges</i>

Preferred (In-Network) benefits – *continued on next page*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does *not* apply. There is no calendar year deductible under Basic Option.

Preferred (In-Network) benefits (continued)

Authorization Procedures

Standard Option: To be eligible to receive Preferred mental health and substance abuse benefits you must see a Preferred provider, obtain a treatment plan, and follow the applicable authorization processes.

To locate a Preferred provider, please refer to your PPO directory, visit our Web site at www.fepblue.org, or contact us at the mental health and substance abuse phone number shown on the back of your ID card.

Basic Option: To be eligible to receive mental health and substance abuse benefits, you must call us for prior approval at the mental health and substance abuse phone number on the back of your ID card before you receive care. We will then provide you with the names and phone numbers of several Preferred providers to choose from and tell you how many visits we are initially approving.

Precertification

You must get precertification of inpatient hospital stays; failure to do so will result in a \$500 penalty. Please refer to the precertification information listed in Section 3 for additional information.

Prior Approval

Standard Option: Prior approval is required for partial hospitalization and intensive outpatient treatment programs.

Basic Option: Prior approval is required for all mental health and substance abuse services.

Prior to starting treatment, you, someone acting on your behalf, your physician, or your hospital must call us at the mental health and substance abuse phone number on the back of your ID card. We will not pay for mental health and substance abuse services under Basic Option or for partial hospitalization or intensive outpatient treatment programs under Standard Option, even at Preferred facilities, until you obtain prior approval.

Treatment Plans

Standard Option: We provide Preferred benefits only when you receive care as part of a treatment plan that we have approved. In order to maximize your benefits, your provider must submit a treatment plan to us **prior to your ninth outpatient visit**. When we approve the treatment plan, we will give your provider authorization for additional visits or services. The services or number of additional visits authorized will depend on the treatment plan. We may need to request updated treatment plans as your treatment progresses. If a treatment plan is not submitted or approved, we will provide only Non-preferred (out-of-network) benefits. If you change providers, a new treatment plan must be submitted. We will be flexible in allowing additional visits while your treatment plan is being prepared or under review.

Basic Option: We will work directly with your provider and may request a treatment plan from your provider.

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.

Preferred Limitation

Under Standard Option, if you do not obtain an approved treatment plan, we will provide only Non-preferred (out-of-network) benefits.

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Non-preferred (Out-of-Network) benefits	You Pay – Standard Option	You Pay – Basic Option
<p>Professional services, including individual or group therapy, by providers such as psychiatrists, psychologists, clinical social workers, or psychiatric nurses, for:</p> <ul style="list-style-type: none"> • Office and home visits • In a hospital outpatient department (except for emergency rooms) • Psychotherapy for smoking cessation 	<p>40% of the Plan allowance for up to two hours per visit and up to 25 outpatient visits per calendar year; all charges after 25 visits*. You may also be responsible for any difference between the Plan allowance and the billed amount.</p> <p>*The 25-visit limit is a combined maximum for all outpatient professional care, partial hospitalization, intensive outpatient treatment, and outpatient facility care, whether performed by Preferred or Non-preferred providers, or applied to your calendar year deductible.</p>	<p>Participating/Non-participating: You pay all charges</p>
<p>Other services:</p> <ul style="list-style-type: none"> • Pharmacotherapy (medication management) • Psychological testing 	<p>25% of the Plan allowance. You may also be responsible for any difference between the Plan allowance and the billed amount.</p> <p>Note: Other services are not subject to the 25-visit limitation.</p>	<p>Participating/Non-participating: You pay all charges</p>
<p>Inpatient visits</p>	<p>40% of the Plan allowance up to 100 days per calendar year; all charges after 100 days. You may also be responsible for any difference between the Plan allowance and the billed amount.</p>	<p>Participating/Non-participating: You pay all charges</p>

Non-preferred (Out-of-Network) benefits – *continued on next page*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Non-preferred (Out-of-Network) benefits <i>(continued)</i>	You Pay – Standard Option	You Pay – Basic Option
<p>Inpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services <p>You must get precertification of inpatient hospital stays; failure to do so will result in a \$500 penalty.</p>	<p>\$400 copayment per day (No deductible) up to 100 days per calendar year; all charges after 100 days</p>	<p>Member/Non-member: You pay all charges</p>
<p>Outpatient services provided and billed by a hospital or other covered facility</p> <ul style="list-style-type: none"> • Psychological testing 	<p>25% of the Plan allowance, plus any difference between the Plan allowance and the billed amount</p> <p>Note: Psychological testing is not subject to the visit limitations.</p>	<p>Member/Non-member: You pay all charges</p>
<p>Partial hospitalization and intensive outpatient treatment</p>	<p>25% of the Plan allowance, plus any difference between the Plan allowance and the billed amount; all charges after 25 visits*</p> <p>Note: Visits that you pay for while meeting your deductible count toward the limit cited above.</p> <p>*The 25-visit limit is a combined maximum for all outpatient professional care, partial hospitalization, intensive outpatient treatment, and outpatient facility care, whether performed by Preferred or Non-preferred providers, or applied to your calendar year deductible.</p>	<p>Participating/Member or Non-participating/Non-member: You pay all charges</p>

Non-preferred (Out-of-Network) benefits – *continued on next page*

Note: The calendar year deductible applies to almost all Standard Option benefits in this Section.
 We say "(No deductible)" when the Standard Option deductible does *not* apply.
There is no calendar year deductible under Basic Option.

Non-preferred (Out-of-Network) benefits <i>(continued)</i>	You Pay – Standard Option	You Pay – Basic Option
<p>Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a treatment facility for rehabilitative treatment of alcoholism or substance abuse</p>	<p>Non-preferred facility: \$400 copayment per day (No deductible); all charges after 28 days per lifetime</p> <p>Non-preferred professional: 40% of the Plan allowance; all charges after 28 days per lifetime. You may also be responsible for any difference between the Plan allowance and the billed amount.</p> <p>Note: Non-preferred inpatient care for the treatment of substance abuse is limited to one treatment program (28-day maximum) per lifetime.</p>	<p>Member/Non-member: You pay all charges</p> <p>Participating/Non-participating: You pay all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Marital, family, educational, or other counseling or training services</i> • <i>Services performed by a noncovered provider</i> • <i>Testing and treatment for learning disabilities and mental retardation</i> • <i>Services performed or billed by schools, residential treatment centers, halfway houses, or members of their staffs</i> • <i>Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Lifetime maximum

Non-preferred inpatient care for the treatment of substance abuse is limited to one treatment program (28-day maximum) per lifetime under **Standard Option**.

Precertification

You must get precertification of the medical necessity of your admission to a hospital or other covered facility. Report emergency admissions within two business days following the day of admission, even if you have been discharged. Otherwise, we will reduce the benefits payable by \$500. See Section 3 for more information on precertification.

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

- Section 4, *Your costs for covered services*, for information about catastrophic protection for mental health and substance abuse benefits.
- Section 7, *Filing a claim for covered services*, for information about submitting Non-preferred claims.

Section 5(f) Prescription drug benefits

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Here are some important things you should keep in mind about these benefits:

- We cover prescription drugs and supplies, as described in the chart beginning on page 81.
- 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.
- **Under Standard Option**, the calendar year deductible does **not** apply to prescriptions filled through the Retail Pharmacy Program or Mail Service Prescription Drug Program. We added “(calendar year deductible applies)” when it applies.
- **Under Basic Option**, there is **no calendar year deductible**.
- **YOU MUST GET PRIOR APPROVAL FOR CERTAIN DRUGS, and prior approval must be renewed periodically. Please refer to the prior approval information shown on page 85 of this Section and in Section 3.** Prior approval is part of our Patient Safety and Quality Monitoring (PSQM) program. See page 85 of this Section for more information about this important program.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **Under Standard Option**, PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See page 12 for the exceptions to this requirement.**
- Please note that retail pharmacies and internet pharmacies that are Preferred under Standard Option are not necessarily Preferred under Basic Option. Refer to page 82 for information about locating Preferred pharmacies.
- **Under Standard Option**, you may use the Mail Service Prescription Drug Program to fill your prescriptions.
- **Under Basic Option**, the Mail Service Prescription Drug Program **is not** available.

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

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

Under Standard Option, you may fill prescriptions at a Preferred retail pharmacy, through a Preferred internet pharmacy, at a Non-preferred retail pharmacy, or through our Mail Service Prescription Drug Program. Under Standard Option, we pay a higher level of benefits when you use a Preferred retail pharmacy, a Preferred internet pharmacy, or our Mail Service Prescription Drug Program.

Under Basic Option, you must fill prescriptions only at a Preferred retail pharmacy or through a Preferred internet pharmacy in order to receive benefits.

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

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

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

Note: Before filling your prescription, please check the formulary status of your medication. Other than changes resulting from new drugs or safety issues, the formulary list is updated twice a year. Prescription drugs are reviewed by the Plan for safety and clinical efficacy. Drugs determined to be of equal therapeutic value and similar safety and efficacy are then evaluated on the basis of cost. Using lower cost formulary drugs will provide you with a high quality, cost-effective prescription drug benefit.

You can view our formulary on our Web site at www.fepblue.org or request a copy by mail by calling 1-800-624-5060 (TDD: 1-800-624-5077). Any savings we receive on the cost of drugs purchased under this Plan from drug manufacturers are credited to the reserves held for this Plan.

- **Generic equivalents.**

Standard Option: By submitting your prescription (or those of family members covered by the Plan) to your retail pharmacy or the Mail Service Prescription Drug Program, you authorize them to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a brand-name drug.

Basic Option: By filling your prescriptions (or those of family members covered by the Plan) at a Preferred retail pharmacy or through a Preferred internet pharmacy, you authorize the pharmacist to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a brand-name drug.

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

You can save money by using generic drugs. However, you and your doctor have the option to request a brand-name drug even if a generic option is available. Using the most cost-effective medication saves money.

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

Standard Option: You may purchase **up to** a 90-day supply of covered drugs and supplies through the Retail Pharmacy Program. You may purchase a supply of **more than** 21 days **up to** 90 days through the Mail Service Prescription Drug Program for a single copayment.

Basic Option: When you fill a prescription for the first time, you may purchase **up to** a 34-day supply for a single copayment. For additional copayments, you may purchase **up to** a 90-day supply for continuing prescriptions and for refills.

Note: Certain drugs such as narcotics may have additional FDA limits on the quantities that a pharmacy may dispense. In addition, pharmacy dispensing practices are regulated by the state where they are located and may also be determined by individual pharmacies. In most cases, refills cannot be obtained until 75% of the prescription has been used. Call us or visit our Web site if you have any questions about dispensing limits. Please note that in the event of a national or other emergency, or if you are a reservist or National Guard member who is called to active military duty, you should contact us regarding your prescription drug needs. See the contact information below.

- **Important contact information.**

Standard Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077); Mail Service Prescription Drug Program: 1-800-262-7890 (TDD: 1-866-409-8525); or www.fepblue.org.

Basic Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077) or www.fepblue.org.

Covered medications and supplies	You Pay – Standard Option	You Pay – Basic Option
<ul style="list-style-type: none"> • Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase <p><i>Note:</i> See Section 5(a), page 42, for our coverage of medical foods for children with inborn errors of amino acid metabolism and for medical foods and nutritional supplements when administered by catheter or nasogastric tube.</p> <ul style="list-style-type: none"> • Insulin • Needles and disposable syringes for the administration of covered medications • Drugs to aid smoking cessation that require a prescription by Federal law <p><i>Note:</i> Prior approval is required if drug treatment extends beyond the initial course of treatment. See Section 3 for more information.</p> <ul style="list-style-type: none"> • Contraceptive drugs and devices, limited to: <ul style="list-style-type: none"> – Depo-Provera* – Diaphragms and contraceptive rings* – Intrauterine devices (IUDs) – Implantable contraceptives* – Oral and transdermal contraceptives <p>*available only through retail and internet pharmacies</p> <p><i>Note:</i> See Family planning in Section 5(a).</p>	<p>See following pages</p>	<p>See following pages</p>

Covered medications and supplies – *continued on next page*

Covered medications and supplies (continued)	You Pay – Standard Option	You Pay – Basic Option
<p>Here is how to obtain your prescription drugs and supplies:</p> <p>Preferred Retail Pharmacies</p> <ul style="list-style-type: none"> • Make sure you have your Plan ID card when you're ready to purchase your prescription • Go to any Preferred retail pharmacy, <p style="text-align: center;">or</p> <ul style="list-style-type: none"> • Visit our special Web site, www.fepblue.org, click on "Pharmacy Programs," and follow the FEP Retail Pharmacy Providers link to fill your prescription and receive home delivery • For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site, www.fepblue.org <p>Note: Please be sure to request the Preferred retail or internet pharmacy listing for your specific option. Retail and internet pharmacies that are Preferred under Standard Option are not necessarily Preferred under Basic Option.</p> <p>Note: Retail and internet pharmacies that are Preferred for prescription drugs are not necessarily Preferred for durable medical equipment (DME) and medical supplies. To receive Preferred benefits for DME and covered medical supplies, you must use a Preferred DME or medical supply provider. See Section 5(a) for the benefit levels that apply to DME and medical supplies.</p> <p>Note: For prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility, we provide benefits as shown on this page for retail pharmacy-obtained prescription drugs, as long as the pharmacy supplying the prescription drugs to the facility is a Preferred pharmacy. For a list of the Preferred Network Long Term Care pharmacies, call 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site at www.fepblue.org. For benefit information about prescription drugs supplied by Non-preferred pharmacies, please refer to the next page.</p> <p>Note: For coordination of benefits purposes, if you need a statement of Preferred retail pharmacy benefits in order to file claims with your other coverage when this Plan is the primary payer, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our Web site at www.fepblue.org.</p>	<p>25% of the Plan allowance</p>	<p>First-time purchase of a new prescription up to a 34-day supply:</p> <p>Generic drug: \$10 copayment</p> <p>Formulary brand-name drug: \$25 copayment</p> <p>Non-formulary brand-name drug: 50% of Plan allowance (\$35 minimum)</p> <p>Refills or continuing prescriptions up to a 90-day supply:</p> <p>Generic drug: \$10 copayment for each purchase of up to a 34-day supply (\$30 copayment for 90-day supply)</p> <p>Formulary brand-name drug: \$25 copayment for each purchase of up to a 34-day supply (\$75 copayment for 90-day supply)</p> <p>Non-formulary brand-name drug: 50% of Plan allowance (\$35 minimum for each purchase of up to a 34-day supply, or \$105 minimum for 90-day supply)</p> <p>Note: If there is no generic equivalent available, you must still pay the brand-name copayment when you receive a brand-name drug.</p> <p>Note: For generic and brand-name drug purchases, if the cost of your prescription is less than your cost-sharing amount noted above, you pay only the cost of your prescription.</p>

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay – Standard Option	You Pay – Basic Option
<p>Non-preferred Retail Pharmacies</p>	<p>45% of the Plan allowance (Average wholesale price – AWP), plus any difference between our allowance and the billed amount</p> <p>Note: If you use a Non-preferred retail pharmacy, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.</p>	<p><i>All charges</i></p>
<p>Mail Service Prescription Drug Program</p> <p>Under Standard Option, if your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you can use this service for your prescriptions and refills.</p> <p>Please refer to Section 7 for instructions on how to use the Mail Service Prescription Drug Program.</p> <p>Note: Not all drugs are available through the Mail Service Prescription Drug Program.</p>	<p>Mail Service Program: \$10 generic \$35 brand-name</p> <p>Note: If there is no generic equivalent available, you must still pay the brand-name copayment when you receive a brand-name drug.</p> <p>Note: If the cost of your prescription is less than your copayment, you pay only the cost of your prescription. The Mail Service Prescription Drug Program will charge you the lesser of the prescription cost or the copayment when you place your order. If you have already sent in your copayment, they will credit your account with any difference.</p>	<p>No benefit</p> <p>Note: You may request home delivery of your internet prescription drug purchases. See page 82 of this Section for our payment levels for drugs obtained through Preferred retail and internet pharmacies.</p>

Covered medications and supplies – continued on next page

Covered medications and supplies <i>(continued)</i>	You Pay – Standard Option	You Pay – Basic Option
<p>Drugs from other sources</p> <ul style="list-style-type: none"> • Covered prescription drugs and supplies not obtained at a retail pharmacy, through an internet pharmacy, or, for Standard Option only, through the Mail Service Prescription Drug Program <p><i>Note:</i> Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription.</p> <p><i>Note:</i> For covered prescription drugs and supplies purchased outside of the United States and Puerto Rico, please submit claims on an Overseas Claim Form. See Section 5(i) for information on how to file claims for overseas services.</p> <ul style="list-style-type: none"> • Please refer to the Sections indicated for additional benefit information when you purchase drugs from a: <ul style="list-style-type: none"> – Physician’s office – Section 5(a) – Hospital (inpatient or outpatient) – Section 5(c) – Hospice agency – Section 5(c) • Please refer to page 82 for retail pharmacy-obtained prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility 	<p>Preferred: 10% of the Plan allowance (calendar year deductible applies)</p> <p>Participating/Member: 25% of the Plan allowance (calendar year deductible applies)</p> <p>Non-participating/Non-member: 25% of the Plan allowance (calendar year deductible applies); plus any difference between our allowance and the billed amount</p>	<p>Preferred: 30% of the Plan allowance</p> <p>Participating/Member or Non-participating/Non-member: You pay all charges</p>

Covered medications and supplies – *continued on next page*

Covered medications and supplies (continued)	You Pay – Standard Option	You Pay – Basic Option
<p>Patient Safety and Quality Monitoring (PSQM)</p> <p>We have a special program to promote patient safety and monitor health care quality. Our Patient Safety and Quality Monitoring (PSQM) program features a set of closely aligned programs that are designed to promote the safe and appropriate use of medications. Examples of these programs include:</p> <ul style="list-style-type: none"> • Prior approval – As described below, this program requires that approval be obtained for certain prescription drugs and supplies before we provide benefits for them. • Safety checks – Before your prescription is filled, we perform quality and safety checks for usage precautions, drug interactions, drug duplication, excessive use, and frequency of refills. • Quantity allowances – Specific allowances for several medications are based on FDA-approved recommendations, clinical studies, and manufacturer guidelines. <p>For more information about our PSQM program, including listings of drugs subject to prior approval or quantity allowances, visit our Web site at www.fepblue.org or call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077).</p> <p>Prior Approval</p> <p>As part of our Patient Safety and Quality Monitoring (PSQM) program (see above), you must make sure that your physician obtains prior approval for certain prescription drugs and supplies in order to use your prescription drug coverage. Prior approval must be renewed periodically. To obtain a list of these drugs and supplies and to obtain prior approval request forms, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077). You can also obtain the list through our Web site at www.fepblue.org. Please read Section 3 for more information about prior approval.</p> <p>Note: If your prescription requires prior approval and you have not yet obtained prior approval, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.</p>		

Covered medications and supplies – continued on next page

Covered medications and supplies (continued)	You Pay – Standard Option	You Pay – Basic Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs and supplies for weight loss</i> • <i>Drugs for orthodontic care, dental implants, and periodontal disease</i> • <i>Medications and orally taken nutritional supplements that do not require a prescription under Federal law even if your doctor prescribes them or if a prescription is required under your State law</i> <p><i>Note:</i> See Section 5(a), page 42, for our coverage of medical foods for children with inborn errors of amino acid metabolism and for medical foods and nutritional supplements when administered by catheter or nasogastric tube.</p> <ul style="list-style-type: none"> • <i>Drugs for which prior approval has been denied or not obtained</i> • <i>Infant formula other than described on page 42</i> • <i>Drugs and supplies related to sex transformations, sexual dysfunction, or sexual inadequacy</i> • <i>Drugs purchased through the mail or internet from pharmacies outside the United States by members located in the United States</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Section 5(g) Special features

Special feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and/or direct the provision of Plan benefits to a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will receive it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. <p><i>Note:</i> Under the Blue Cross and Blue Shield Service Benefit Plan, the flexible benefits option is also referred to as “case management.”</p>
Online customer and claims service	<p>By visiting our Web site, www.fepblue.org, you may check the status of your claims, change your address of record, request claim forms, request a duplicate or replacement Service Benefit Plan ID card, and access a range of other service and information options. It’s easy! Give it a try and share any suggestions you may have for improved service by using the site’s “Contact Us” feature.</p>
24-hour nurse line	<p>Help with health concerns is available 24 hours a day, 365 days a year, by calling a toll-free telephone number, 1-888-258-3432, or by accessing our Web site, www.fepblue.org. The service, called Blue Health Connection, offers health advice or health information and counseling by registered nurses. Also available is the AudioHealth Library with hundreds of tapes, ranging from first aid to infectious diseases to general health issues.</p> <p>You can get information about health care resources to help you find local doctors, hospitals, or other health care services affiliated with the Blue Cross and Blue Shield Service Benefit Plan. Contact us at the number above or visit our Web site for more information. Please keep in mind that benefits for any health care services you may seek after using Blue Health Connection are subject to the terms of your coverage under this Plan.</p>
Services for the deaf and hearing impaired	<p>All Blue Cross and Blue Shield Plans provide TDD access for the hearing impaired to access information and receive answers to their questions.</p>
Web accessibility for the visually impaired	<p>Our Web site provides visually impaired individuals with access to important program information and services. Look for the “Web Accessibility” option at www.fepblue.org.</p>
Travel benefit/services overseas	<p>Please refer to Section 5(i) for benefit and claims information for care you receive outside the United States and Puerto Rico.</p>
Health support programs	<p>The Service Benefit Plan is developing and may offer patient education and support programs for certain diagnoses in select locations on a pilot basis. One program we have developed is the Patient Safety Risk Reduction Pilot Program. We will notify you if this pilot or other programs are available in your area.</p>
Healthy Families Program	<p>Healthy Families is a national health education prevention program that provides information to members and their families. The educational mailings assist members to understand and adopt healthy behaviors, reduce risk of injury and disease, and improve existing chronic conditions.</p>

Section 5(h) Dental benefits

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Here are some 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.
- **Under Standard Option**, the calendar year deductible applies only to the accidental injury benefit below. We added “(calendar year deductible applies)” when it applies.
- **Under Basic Option**, there is **no calendar year deductible**.
- **Under Basic Option**, you must use **Preferred providers in order to receive benefits, except in cases of dental care resulting from an accidental injury as described below**.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **Note:** We cover hospitalization for dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient (even if the dental procedure itself is not covered). See Section 5(c) for inpatient hospital benefits.

Accidental injury benefit	You Pay – Standard Option	You Pay – Basic Option
<p>We provide benefits for services, supplies, or appliances for dental care necessary to promptly repair injury to sound natural teeth required as a result of, and directly related to, an accidental injury.</p> <p>Note: An accidental injury is an injury caused by an external force or element such as a blow or fall and that requires immediate attention. Injuries to the teeth while eating are not considered accidental injuries.</p> <p>Note: A sound natural tooth is a tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.</p> <p>Note: Treatment must be started promptly and completed within 12 months of the accident.</p>	<p>Preferred: 10% of the Plan allowance (calendar year deductible applies)</p> <p>Participating: 25% of the Plan allowance (calendar year deductible applies)</p> <p>Non-participating: 25% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the billed amount</p> <p>Note: Under Standard Option, we first provide benefits as shown in the Schedule of Dental Allowances on the following pages. We then pay benefits as shown here for any balances.</p>	<p>\$20 copayment</p> <p>Note: We provide benefits for accidental dental injury care in cases of medical emergency when performed by Preferred or Non-preferred providers. See Section 5(d) for the criteria we use to determine if emergency care is required. You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount.</p> <p>Note: All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.</p>

Dental benefits – *continued on next page*

Dental benefits

What is Covered

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

Basic Option dental benefits appear on page 93.

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

Preferred Dental Network

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

Note: Dentists who are in our Preferred Dental Network are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as oral and maxillofacial surgery).

Standard Option dental benefits

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

Standard Option dental benefits	Standard Option Only		
	We pay		
Covered service			
Clinical oral evaluations	<u>To age 13</u>	<u>Age 13 and over</u>	
Periodic oral evaluation*	\$12	\$8	
Limited oral evaluation	\$14	\$9	
Comprehensive oral evaluation	\$14	\$9	
Detailed and extensive oral evaluation	\$14	\$9	
*Limited to two per person per calendar year			All charges in excess of the scheduled amounts listed to the left
Radiographs			
Intraoral complete series	\$36	\$22	Note: For services performed by dentists in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Intraoral periapical first film	\$7	\$5	
Intraoral periapical each additional film	\$4	\$3	
Intraoral occlusal film	\$12	\$7	
Extraoral first film	\$16	\$10	
Extraoral each additional film	\$6	\$4	
Bitewing – single film	\$9	\$6	
Bitewings – two films	\$14	\$9	
Bitewings – four films	\$19	\$12	

Dental benefits – continued on next page

Standard Option dental benefits (continued)	Standard Option Only		
Covered service	We pay		You pay
	<u>To age 13</u>	<u>Age 13 and over</u>	
Radiographs – continued			
Bitewings – vertical	\$12	\$7	
Posterior-anterior or lateral skull and facial bone survey film	\$45	\$28	
Panoramic film	\$36	\$23	
Tests and laboratory exams			
Pulp vitality tests	\$11	\$7	
Palliative treatment			
Palliative (emergency) treatment of dental pain – minor procedure	\$24	\$15	
Sedative filling	\$24	\$15	
Preventive			
Prophylaxis – adult*	---	\$16	
Prophylaxis – child*	\$22	\$14	
Topical application of fluoride (including prophylaxis) – child*	\$35	\$22	
Topical application of fluoride (prophylaxis not included) – child	\$13	\$8	
Topical application of fluoride (prophylaxis not included) – adult	---	\$8	
Topical application of fluoride (including prophylaxis) – adult*	---	\$24	
<i>*Limited to two per person per calendar year</i>			
Space maintenance (passive appliances)			
Space maintainer – fixed – unilateral	\$94	\$59	
Space maintainer – fixed – bilateral	\$139	\$87	
Space maintainer – removable – unilateral	\$94	\$59	
Space maintainer – removable – bilateral	\$139	\$87	
Recementation of space maintainer	\$22	\$14	

All charges in excess of the scheduled amounts listed to the left

Note: For services performed by dentists in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).

Dental benefits – continued on next page

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

Dental benefits – *continued on next page*

Standard Option dental benefits <i>(continued)</i>	Standard Option Only		
Covered service	We pay		You pay
	<u>To age 13</u>	<u>Age 13 and over</u>	
Inlay restorations – continued			
Inlay – composite/resin – one surface	\$25	\$16	
Inlay – composite/resin – two surfaces	\$37	\$23	
Inlay – composite/resin – three or more surfaces	\$50	\$31	
Other restorative services			
Pin retention – per tooth, in addition to restoration	\$13	\$8	All charges in excess of the scheduled amounts listed to the left
Extractions – includes local anesthesia and routine post-operative care			<i>Note:</i> For services performed by dentists in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Extraction, erupted tooth or exposed root	\$30	\$19	
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$43	\$27	
Surgical removal of residual tooth roots (cutting procedure)	\$71	\$45	
General anesthesia in connection with covered extractions	\$43	\$27	
<i>Not covered: Any service not specifically listed above</i>	<i>Nothing</i>	<i>Nothing</i>	<i>All charges</i>

Dental benefits – *continued on next page*

Basic Option dental benefits

Under Basic Option, we provide benefits for the services listed below. You pay a \$20 copayment for each evaluation, and we pay any balances in full. This is a complete list of dental services covered under this benefit for Basic Option. You **must** use a Preferred dentist in order to receive benefits. For a list of Preferred dentists, please refer to the Preferred provider directory, visit our Web site at www.fepblue.org, or call us at the customer service number on the back of your ID card.

Basic Option dental benefits	Basic Option Only	
	We pay	You pay
<p>Clinical oral evaluations</p> <p>Periodic oral evaluation*</p> <p>Limited oral evaluation</p> <p>Comprehensive oral evaluation*</p> <p>*Benefits are limited to a combined total of 2 evaluations per person per calendar year</p>	<p>Preferred: All charges in excess of your \$20 copayment</p> <p>Participating/Non-participating: Nothing</p>	<p>Preferred: \$20 copayment per evaluation</p> <p>Participating/Non-participating: You pay all charges</p>
<p>Radiographs</p> <p>Intraoral – complete series including bitewings (limited to 1 complete series every 3 years)</p> <p>Bitewing – single film*</p> <p>Bitewings – two films*</p> <p>Bitewings – four films*</p> <p>*Benefits are limited to a combined total of 4 films per person per calendar year</p>		
<p>Preventive</p> <p>Prophylaxis – adult (up to 2 per calendar year)</p> <p>Prophylaxis – child (up to 2 per calendar year)*</p> <p>Topical application of fluoride (including prophylaxis) – child (up to 2 per calendar year)*</p> <p>Topical application of fluoride (prophylaxis not included) – child (up to 2 per calendar year)</p> <p>Sealant – per tooth, first and second molars only (once per tooth for children up to age 16 only)</p> <p>*Benefits are limited to a combined total of 2 visits per person per calendar year</p>		
<p><i>Not covered: Any service not specifically listed above</i></p>	<p><i>Nothing</i></p>	<p><i>All charges</i></p>

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

If you travel or live outside the United States and Puerto Rico, you are still entitled to the benefits described in this brochure. Unless otherwise noted in this section, the same definitions, limitations, and exclusions also apply.

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

Overseas claims payment

For professional care you receive overseas, we provide benefits at Preferred benefit levels using an Overseas Fee Schedule as our Plan allowance. **Under Standard Option**, you must pay any difference between our payment and the amount billed, in addition to any applicable deductible, coinsurance, and/or copayment amounts. You must also pay any charges for noncovered services.

Under Basic Option, you pay any difference between our payment and the amount billed, as well as the applicable copayment or coinsurance. You must also pay any charges for noncovered services. **The requirement to use Preferred providers in order to receive benefits under Basic Option does not apply when you receive care outside the United States and Puerto Rico.**

For facility care you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options** after you pay the applicable copayment or coinsurance. Standard Option members are also responsible for any amounts applied to the calendar year deductible for certain outpatient facility services – please see pages 61-63.

For dental care you receive overseas, we provide benefits as described in Section 5(h). **Under Standard Option**, you must pay any difference between the Schedule of Dental Allowances and the dentist's charge, in addition to any charges for noncovered services. **Under Basic Option**, you must pay the \$20 copayment plus any difference between our payment and the dentist's charge, as well as any charges for noncovered services.

Worldwide Assistance Center

We have a network of participating hospitals overseas that will file your claims for inpatient facility care for you – without an advance payment for the covered services you receive. The Worldwide Assistance Center can help you locate a hospital in our network near where you are staying. You may also view a list of our network hospitals on our Web site, www.fepblue.org. Although we do not have a network of professionals overseas, the Worldwide Assistance Center can also help you locate a physician. You will have to file a claim to us for reimbursement for professional services.

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

Filing overseas claims

- **Hospital and physician care**

Most overseas providers are under no obligation to file claims on behalf of our members. **You may need to pay for the services at the time you receive them and then submit a claim to us for reimbursement.** To file a claim for covered hospital and physician services received outside the United States and Puerto Rico, send a completed Overseas Claim Form and itemized bills to: FEP Overseas Claims Section, CareFirst Blue Cross Blue Shield, P.O. Box 96242, Washington, DC 20090-6242. We will provide translation and currency conversion services for your overseas claims. Send any written inquiries concerning the processing of your overseas claims to this address or call us at 1-888-999-9862, using the appropriate AT&T country codes available on our Web site under Contact Us. You may also obtain Overseas Claim Forms from this address, from our Web site (www.fepblue.org), or from your Local Plan.

- **Pharmacy benefits**

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

Please note that under both **Standard and Basic Options**, you may fill your prescriptions through a Preferred internet pharmacy only if the prescribing physician is licensed in the United States or Puerto Rico.

Under Standard Option, you may order your prescription drugs from the Mail Service Prescription Drug Program only if:

- a) Your address includes a U.S. zip code (such as with APO and FPO addresses and in U.S. territories) and
- b) The prescribing physician is licensed in the United States or Puerto Rico.

Please see page 83 for more information about using this program.

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

Section 5(j) Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB dispute regarding these benefits.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. In addition, these services are not eligible for benefits under the FEHB program. Please do not file a claim with us for these services.

Discount Drug Program

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

For sexual dysfunction: Caverject injection, Edex injection, Muse suppository, and Viagra tablet;

For weight loss: Meridia capsule and Xenical capsule;

For hair removal: Vaniqa cream;

For hair growth: Propecia; and

For pigmenting/depigmenting: Eldoquin, Solaquin, and Benoquin.

Drugs may be added to this list as they are approved by the Food and Drug Administration (FDA).

To use the program, simply present a valid prescription and your Service Benefit Plan ID card at a network retail pharmacy (same as you do for drugs covered by the regular drug benefit). The pharmacist will process the prescription and ask you for payment in full at the negotiated discount rate. If you have any questions, please call 1-800-624-5060.

Vision Care Program

Service Benefit Plan members can receive routine eye exams, frames, lenses, conventional contact lenses, and laser vision correction at substantial savings when using EyeMed Vision Care providers. Members have access to over 15,000 providers at 8,000 locations, including LensCrafters®, independent optometrists, ophthalmologists, and opticians.

For a complete description of the program or to find a provider near you, visit our Web site at www.fepblue.org or call EyeMed at 1-800-551-3337 from 8:00 a.m. to 11:00 p.m. eastern time, Monday through Saturday, and from 11:00 a.m. to 8:00 p.m. on Sunday.

Members can save on replacement contact lenses by visiting www.eyemedcontacts.com or calling 1-800-508-1399; however, a \$2.95 administration fee applies to phone orders. Members can also save 15% off the retail price or 5% off promotional pricing on LASIK or PRK vision correction procedures. Simply call 1-877-552-7376 for the nearest laser facility and to receive authorization for the discount.

There are no enrollment fees or claim forms to be filed in this program. All charges for eye exams and eyewear are handled directly between you and the EyeMed provider.

Complementary Health Care

Service Benefit Plan members have new choices in complementary health care. Members can purchase over 2,400 discounted health care products such as vitamins and dietary supplements through the Internet retail program Healthyroads. There is no enrollment fee to participate, and members can access Healthyroads through www.fepblue.org.

Members may also purchase a \$50 yearly membership and gain access to a national network of chiropractors, acupuncturists, and massage therapists, and dietitians (where available) at discounted rates, as well as best pricing at fitness clubs. Members purchasing this option receive an enrollment packet from American Specialty Health (ASH) Networks, Inc. Members call providers directly to schedule appointments. No physician referral is required and there are no claim forms. All charges are handled directly between you and the ASH Networks providers.

For more information, visit our Web site at www.fepblue.org or call 1-877-258-7283 from 8:00 a.m. to 9:00 p.m. eastern time, Monday through Friday. The discount provider network is available to members nationwide, unless restricted by state law or regulation.

Federal DentalBlue

Federal DentalBlue is an optional product with an additional premium that supplements the dental benefits included in your Service Benefit Plan coverage. To apply for Federal DentalBlue, you must be:

1. Enrolled in Standard Option and reside in one of the following Plan areas: Alabama, Oklahoma, or Washington State (only counties served by Regence BlueShield); or
2. Enrolled in Basic Option and reside in Alabama or Oklahoma.

To purchase this additional coverage, complete and sign the Federal DentalBlue enrollment form, which you can obtain from your Local Plan.

Many other Blue Cross and Blue Shield Plans offer dental insurance to Service Benefit Plan members for an additional premium. For more information, contact your Local Plan about the availability of a non-FEHB dental program in your area.

Medicare Prepaid Plan Enrollment

Some local Blue Cross and Blue Shield Plans offer Medicare recipients the opportunity to enroll in a Medicare prepaid plan without payment of an FEHB premium. Contact your local Blue Cross and Blue Shield Plan to find out if a Medicare prepaid plan is available in your area and the cost, if any, of that enrollment.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs, or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations, sexual dysfunction, or sexual inadequacy;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you would not be charged for if you had no health insurance coverage;
- Services, drugs, or supplies you receive without charge while in active military service;
- Amounts charged that neither you nor we are legally obligated to pay, such as amounts over the Medicare limiting charge or equivalent Medicare amount as described in Section 4 under *Your costs for covered services*, or State premium taxes, however applied;
- Services, drugs, or supplies you receive from immediate relatives or household members, such as spouse, parent, child, brother, or sister, by blood, marriage, or adoption;
- Services or supplies (except for medically necessary prescription drugs) that you receive from a noncovered facility, such as an extended care facility or nursing home, except as specifically described in Sections 5(a) and 5(c);
- Services, drugs, or supplies you receive from noncovered providers except in medically underserved areas as specifically described on page 11;
- Services, drugs, or supplies you receive for cosmetic purposes;
- Services, drugs, or supplies for the treatment of obesity, weight reduction, or dietary control, except for gastric bypass surgery or gastric stapling procedures and those nutritional counseling services specifically listed on pages 27, 44, and 59;
- Services you receive from a provider that are outside the scope of the provider's licensure or certification;
- Any dental or oral surgical procedures or drugs involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for the fitting or continued use of dentures, except as specifically described in Section 5(h), *Dental benefits*, and Section 5(b) under *Oral and maxillofacial surgery*;
- Orthodontic care for temporomandibular joint (TMJ) syndrome;
- Services of standby physicians;
- Self-care or self-help training;
- Custodial care;
- Personal comfort items such as beauty and barber services, radio, television, or telephone;
- Routine services, such as periodic physical examinations; screening examinations; immunizations; and services or tests not related to a specific diagnosis, illness, injury, set of symptoms, or maternity care, except for those preventive services specifically covered under *Preventive care, adult and child* in Sections 5(a) and 5(c) and screenings specifically listed on pages 28 and 46;
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay; or
- Services not specifically listed as covered.

Section 7. Filing a claim for covered services

How to claim benefits

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

In most cases, physicians and facilities file claims for you. Just present your Service Benefit Plan ID card when you receive services. Your physician must file on the HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form.

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

- Name of patient and relationship to enrollee;
- Plan identification number of the enrollee;
- Name and address of person or firm providing the service or supply;
- Dates that services or supplies were furnished;
- Diagnosis;
- Type of each service or supply; and
- The charge for each service or supply.

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

In addition:

- You must send a copy of the explanation of benefits (EOB) form from any primary payer [such as the Medicare Summary Notice (MSN)] with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment, home nursing care, and physical, occupational, and speech therapy, require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies that are not received from the Retail Pharmacy Program, through a Preferred internet pharmacy, or through the Mail Service Prescription Drug Program must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, and charge. (See below for information on how to obtain benefits from the Retail Pharmacy Program, a Preferred internet pharmacy, and the Mail Service Prescription Drug Program.)

Prescription drug claims

Preferred Retail/Internet Pharmacies – When you use Preferred retail pharmacies, show your Service Benefit Plan ID card. Preferred retail pharmacies will file your claims for you. To use Preferred internet pharmacies, go to our special Web site, www.fepblue.org, click on “Pharmacy Programs,” and follow the FEP Retail Pharmacy Providers link to fill your prescriptions and receive home delivery. Be sure to have your Service Benefit Plan ID card ready to complete your purchase. We reimburse the Preferred retail or internet pharmacy for your covered drugs and supplies. You pay the applicable coinsurance or copayment.

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

- You do not have a valid Service Benefit Plan ID card;
- You do not use your valid Service Benefit Plan ID card at the time of purchase; or
- You did not obtain prior approval when required (see page 15).

See the following paragraph for claim filing instructions.

Non-Preferred Retail/Internet Pharmacies

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

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

Mail Service Prescription Drug Program

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

- 1) Complete the initial mail order form;
- 2) Enclose your prescription and copayment;
- 3) Mail your order to Caremark, P.O. Box 52056, Phoenix, AZ 85072; and
- 4) Allow approximately two weeks for delivery.

Alternatively, your physician may call in your initial prescription at 1-800-262-7890 (TDD: 1-866-409-8525). You will be billed later for the copayment.

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

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

Records

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

Deadline for filing your claim

Send us your claim and appropriate documentation as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided you submitted the claim as soon as reasonably possible. If we return a claim or part of a claim for additional information, you must resubmit it within 90 days, or before the timely filing period expires, whichever is later.

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

Overseas claims

Please refer to the claims filing information on pages 94 and 95 of this brochure.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

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

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. Write to us at the address shown on your explanation of benefits (EOB) form. You must:</p> <ul style="list-style-type: none">(a) Write to us within 6 months from the date of our decision; and(b) Send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program or Mail Service Prescription Drug Program); and(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">(a) Pay the claim (or, if applicable, precertify your hospital stay or grant your request for prior approval for a service, drug, or supply); or(b) Write to you and maintain our denial – go to step 4; or(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.
3	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">• 90 days after the date of our letter upholding our initial decision; or• 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or• 120 days after we asked for additional information – if we did not send you a decision within 30 days after we received the additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 1, 1900 E Street, NW, Washington, DC 20415-3610.

The disputed claims process (*continued*)

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.

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

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

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

- 5** OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send you a final decision within 60 days. There are no other administrative appeals.

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

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

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

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

- (a) We have not responded yet to your initial claim or request for precertification/prior approval, then call us at the customer service number on the back of your Service Benefit Plan ID card and we will expedite our review; or
- (b) We denied your initial claim or request for precertification/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 1 at 1-202-606-0727 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

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

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

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. For example, we will generally only make up the difference between the primary payer’s benefits payment and 100% of the Plan allowance, subject to our applicable deductible (under Standard Option) and coinsurance or copayment amounts, except when Medicare is the primary payer (see Section 4). Thus, it is possible that the combined payments from both plans may not equal the entire amount billed by the provider.

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

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

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

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

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

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 two 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. (Someone who was a Federal employee on January 1, 1983, or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227) 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.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or both 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 Medicare Part B coverage.

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

- **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. Some things are not covered under the Original Medicare Plan, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. For example, you must continue to obtain prior approval for some prescription drugs and organ/tissue transplants before we will pay benefits. However, you do not have to precertify inpatient hospital stays when Medicare Part A is primary (see page 14 for exception).

Claims process when you have the Original Medicare Plan – You probably will never have 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 the Original Medicare Plan is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will then provide secondary benefits for the covered charges. You will not need to do anything. To find out if you need to do something to file your claims, call us at the customer service number on the back of your Service Benefit Plan ID card or visit our Web site at www.fepblue.org.

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

When Medicare Part A is primary –

- Under **Standard Option**, we will waive our:
 - Inpatient hospital per-admission copayments;
 - Inpatient Non-member hospital coinsurance; and
 - Non-Preferred inpatient per-day copayments for mental conditions/substance abuse care.
- Under **Basic Option**, we will waive our:
 - Inpatient hospital per-day copayments.

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

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

When Medicare Part B is primary –

- Under **Standard Option**, we will waive our:
 - Calendar year deductible;
 - Coinsurance for services and supplies provided by physicians and other covered health care professionals (inpatient and outpatient, including mental conditions and substance abuse care);
 - Copayments for office visits to Preferred physicians and other health care professionals;
 - Copayments for routine physical examinations and preventive (screening) services performed by Preferred physicians, other health care professionals, and facilities; and
 - Outpatient facility coinsurance for medical, surgical, preventive, and mental conditions and substance abuse care.
- Under **Basic Option**, we will waive our:
 - Copayments and coinsurance for care received from covered professional and facility providers.

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

- **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 always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When you – or your covered spouse – are age 65 or over and have Medicare and you. . .	The primary payer for the individual with Medicare is. . .	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) 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 #1 above	✓	
4) 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... <ul style="list-style-type: none"> • You have FEHB coverage on your own or through your spouse who is also an active employee 		✓
<ul style="list-style-type: none"> • You have FEHB coverage through your spouse who is an annuitant 	✓	
5) 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 #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and... <ul style="list-style-type: none"> • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period) 		✓
<ul style="list-style-type: none"> • 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... <ul style="list-style-type: none"> • This Plan was the primary payer before eligibility due to ESRD 		✓ for 30-month coordination period
<ul style="list-style-type: none"> • Medicare was the primary payer before eligibility due to ESRD 	✓	
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

- **Medicare Advantage**

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) in some areas of the country. In most Medicare Advantage plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare Advantage plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare Advantage plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB Plan. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Under Standard Option, we will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles, if you receive services from providers who do not participate in the Medicare Advantage plan.

Under Basic Option, we provide benefits for care received from Preferred providers when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area. However, we will not waive any of our copayments or coinsurance for services you receive from Preferred providers who do not participate in the Medicare Advantage plan. Please remember that you must receive care from Preferred providers in order to receive Basic Option benefits. See page 12 for the exceptions to this requirement.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and 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.

- **Private contract with your physician**

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

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 these programs.

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

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

Contact us if you need more information about subrogation.

Section 10. Definitions of terms we use in this brochure

Accidental injury	An injury caused by an external force or element such as a blow or fall that requires immediate medical attention, including animal bites and poisonings. Note: Injuries to the teeth while eating are not considered accidental injuries. Dental care for accidental injury is limited to dental treatment necessary to repair sound natural teeth.
Admission	The period from entry (admission) as an inpatient into a hospital (or other covered facility) until discharge. In counting days of inpatient care, the date of entry and the date of discharge count as the same day.
Assignment	An authorization by the enrollee or spouse for us to issue payment of benefits directly to the provider. We reserve the right to pay you, the enrollee, directly for all covered services.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Carrier	The Blue Cross and Blue Shield Association, on behalf of the local Blue Cross and Blue Shield Plans.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 16.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 16.
Cosmetic surgery	Any surgical procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form, except for repair of accidental injury, or to restore or correct a part of the body that has been altered as a result of disease or surgery or to correct a congenital anomaly.
Covered services	Services we provide benefits for, as described in this brochure.
Custodial care	<p>Treatment or services, regardless of who recommends them or where they are provided, that a person not medically skilled could perform safely and reasonably, or that mainly assist the patient with daily living activities, such as:</p> <ol style="list-style-type: none">1. Personal care, including help in walking, getting in and out of bed, bathing, eating (by spoon, tube, or gastrostomy), exercising, or dressing;2. Homemaking, such as preparing meals or special diets;3. Moving the patient;4. Acting as companion or sitter;5. Supervising medication that can usually be self-administered; or6. Treatment or services that any person can perform with minimal instruction, such as recording pulse, temperature, and respiration; or administration and monitoring of feeding systems. <p>Custodial care that lasts 90 days or more is sometimes known as Long Term Care. The Carrier, its medical staff, and/or an independent medical review determines which services are custodial care.</p>
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies in a calendar year before we start paying benefits for those services. See page 16.

Durable medical equipment

Equipment and supplies that:

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

Experimental or investigational services

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

A medical treatment or procedure, or a drug, device, or biological product, is experimental or investigational if:

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

Reliable evidence shall mean only:

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

Each Local Plan has a Medical Review department that determines whether a claimed service is experimental or investigational after consulting with internal or external experts or nationally recognized guidelines in a particular field or specialty.

For more detailed information, contact your Local Plan at the customer service telephone number located on the back of your Service Benefit Plan ID card.

Group health coverage

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

Intensive outpatient care

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

Lifetime maximum

The maximum amount the Plan will pay on your behalf for covered services you receive while you are enrolled in your option. Benefit amounts accrued are accumulated in a permanent record regardless of the number of enrollment changes. Please see page 78.

Local Plan

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

Medical necessity

We determine whether services, drugs, supplies, or equipment provided by a hospital or other covered provider are:

1. Appropriate to prevent, diagnose, or treat your condition, illness, or injury;
2. Consistent with standards of good medical practice in the United States;
3. Not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4. Not part of or associated with scholastic education or vocational training of the patient; and
5. In the case of inpatient care, cannot be provided safely on an outpatient basis.

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

Mental conditions/substance abuse

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

Partial hospitalization

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

Plan allowance

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

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

Our PPO allowance includes any known discounts that can be accurately calculated at the time your claim is processed. For PPO facilities, we sometimes refer to our allowance as the “Preferred rate.” The Preferred rate may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf. (See page 89 for special information about limits on the amounts Preferred dentists can charge you under Standard Option.)

- **Participating providers** – Our allowance (which we may refer to as the “PAR” for “Participating Provider Allowance”) is the negotiated amount that these providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with some local Blue Cross and Blue Shield Plans) have agreed to accept as payment in full, when we pay primary benefits. For facilities, we sometimes refer to our allowance as the “Member rate.” The member rate includes any known discounts that can be accurately calculated at the time your claim is processed, and may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf.
- **Non-participating providers** – We have no agreements with these providers. We determine our allowance as follows:
 - For inpatient services by hospitals and other facilities that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is the billed charge or the average semiprivate rate (e.g., for room and board, and other hospital charges) charged for inpatient care by similar institutions in the same area, as determined by your Local Plan;
 - For outpatient services by hospitals and other facilities that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is the billed amount (minus any amounts for noncovered services);
 - For physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount) or 2) 80% of the 2005 Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained. Local Plans determine the UCR amount in different ways. Contact your Local Plan if you need more information. We may refer to our allowance for Non-participating providers as the “NPA” (for “Non-participating Provider Allowance”);
 - For prescription drugs furnished by retail and internet pharmacies that do not contract with Caremark, our allowance is the average wholesale price (“AWP”) of a drug on the date it is dispensed, as set forth in the most current version of First DataBank’s National Drug Data File; and
 - For services you receive outside of the United States and Puerto Rico from providers that do not contract with us or with World Access, Inc., our allowance is an Overseas Fee Schedule that is based on amounts comparable to what Participating providers in the Washington, DC, area have agreed to accept.

Non-participating providers are under no obligation to accept our allowance as payment in full. If you use Non-participating providers, you will be responsible for any difference between our payment and the billed amount (except in certain circumstances – see page 114). In addition, you will be responsible for any applicable deductible, coinsurance, or copayment amounts.

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

In **only** those situations listed below, when the difference between the NPA and the provider's billed amount on an individual claim is greater than \$5,000, your responsibility will be limited to \$5,000 (in addition to any applicable deductible, coinsurance, or copayment amounts), as long as the services are covered.

- When you receive care from a Non-participating radiologist, anesthesiologist, certified registered nurse anesthetist (CRNA), pathologist, neonatologist, or emergency room physician in a Preferred hospital;
- When you receive care in a Member or Non-member hospital from a Non-participating radiologist, anesthesiologist, certified registered nurse anesthetist (CRNA), pathologist, or emergency room physician as part of the emergency services you receive for a medical emergency or accidental injury (see page 67);
- For surgery provided by a Non-participating provider in a Preferred, Member, or Non-member hospital as part of the emergency services you receive for a medical emergency or accidental injury; and
- Ambulance services billed by a Non-participating professional provider and associated with a medical emergency or accidental injury.

For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see pages 18, 94, and 95.

Precertification

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

Preferred provider organization (PPO) arrangement

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

Prior approval

Written assurance that benefits will be provided by:

1. The Local Plan where the services will be performed;
2. The Retail Pharmacy Program (for prescription drugs and supplies purchased through Preferred retail and internet pharmacies) or the Mail Service Prescription Drug Program; or
3. The Blue Cross and Blue Shield Association Clinical Trials Information Unit for certain organ/tissue transplants we cover only in clinical trials. See Section 5(b).

For more information, see the benefit descriptions in Section 5 and *How to get approval for . . . Other services* on pages 14-15. See Section 5(e) for special authorization requirements for mental health and substance abuse benefits.

Routine services

Services that are not related to a specific illness, injury, set of symptoms, or maternity care.

Sound natural tooth

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

Transplant period

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

Us/We/Our

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

You/Your

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

Section 11. FEHB facts

Coverage information

- **No pre-existing condition limitation**

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

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

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

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

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

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

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

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

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

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

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

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

- **Children’s Equity Act**

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2005 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 2004 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.

- **Your medical and claims records are confidential**

We will keep your medical and claims information confidential. Please note that as part of our administration of this contract, we may disclose your medical and claims information (including your prescription drug utilization) to any treating physicians or dispensing pharmacies.

- **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.

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

- **Spouse equity coverage**

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

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

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

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

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

- **Converting to individual coverage**

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

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

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

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

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

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

*

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

Section 12. Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

The Federal Flexible Spending Account Program – FSAFEDS

• What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax Return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax Return, even if you don't have self and family health benefits coverage. **Note:** The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$4,000. **Note:** The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for an HCFSA up to the maximum of \$4,000 each (\$8,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax Return (and who is mentally or physically incapable of self care).
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. **Note:** The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive.

• Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2005 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

- **Online:** visit www.FSAFEDS.com and click on **Enroll**.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (372-3337), Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

SHPS is a Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and is responsible for the enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

- **Who is eligible to enroll?**

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. *However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. You will have until April 30, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through December 31. For example, if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006, to submit claims for eligible expenses.

The [FSAFEDS Calculator](http://www.FSAFEDS.com) at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSA pay for?**

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on pages 123 and 124 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that are NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under the Standard Option of this Plan, typical out-of-pocket expenses include: copayments for hospital stays and office visits, deductible and coinsurance amounts for certain diagnostic tests, and coinsurance amounts for retail pharmacy prescription drug purchases. Other out-of-pocket expenses include amounts that you pay for noncovered services such as routine eye and hearing exams, hearing aids, and certain dental procedures.

Under the Basic Option of this Plan, typical out-of-pocket expenses include: copayments for hospital stays, office visits, and certain retail pharmacy prescription drug purchases. Other out-of-pocket expenses include amounts that you pay for noncovered services and supplies such as care received from Non-preferred providers, certain dental procedures, and physical, speech, and occupational therapies in excess of visit limits.

The IRS governs expenses reimbursable by an HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at: www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 – a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax Return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

Health care expenses

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax Return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax Return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax Return.

Paperless Reimbursement – This plan participates in the FSAFEDS paperless reimbursement program. When you enroll for your HCFSA, you will have the opportunity to enroll for paperless reimbursement. If you do, we will send FSAFEDS the information they need to reimburse you for your out-of-pocket costs so you can avoid filing paper claims in most cases.

Dependent care expenses

The DCFSA generally allows many families to save more than they would with the Federal Tax Credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.FSAFEDS.com and download the [Dependent Care Tax Credit Worksheet](#) from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year, resulting in the forfeiture of funds remaining in your account (the IRS "use-it-or-lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at www.FSAFEDS.com, or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

- **It's important protection**

Why should you consider applying for coverage under the Federal Long Term Care Insurance Program (FLTCIP)?

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," 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. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To find out more and to request an application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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

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Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2005

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

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

Below, an asterisk (*) means the item is subject to the \$250 per person (\$500 per family) calendar year deductible. If you use a Non-PPO physician or other health care professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

Benefits	You Pay	Page
Medical services provided by physicians: <ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office 	PPO: 10%* of our allowance; \$15 per office visit Non-PPO: 25%* of our allowance	25-28
Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient • Outpatient..... 	PPO: \$100 per admission Non-PPO: \$300 per admission PPO: 10%* of our allowance (no deductible for surgery) Non-PPO: 25%* of our allowance (no deductible for surgery)	57-60 61-63
Emergency benefits: <ul style="list-style-type: none"> • Accidental injury..... • Medical emergency 	PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: Any difference between our payment and the billed amount within 72 hours; regular benefits thereafter Regular benefits for physician and hospital care*; 10% of our allowance for ambulance transport services (no deductible)	67-69 70
Mental health and substance abuse treatment.....	In-Network (PPO): Regular cost sharing, such as \$15 office visit copay; \$100 per inpatient admission Out-of-Network (Non-PPO): Benefits are limited	72-78
Prescription drugs.....	Retail Pharmacy Program: <ul style="list-style-type: none"> • PPO: 25% of our allowance; up to a 90-day supply • Non-PPO: 45% of our allowance (AWP); up to a 90-day supply Mail Service Prescription Drug Program: <ul style="list-style-type: none"> • \$10 generic/\$35 brand-name per prescription; up to a 90-day supply 	79-86
Dental care.....	Scheduled allowances for diagnostic and preventive services, fillings, and extractions; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	49, 88-92
Special features: Flexible benefits option; online customer and claims service; 24-hour nurse line; services for deaf and hearing impaired; Web accessibility for the visually impaired; travel benefit/services overseas; health support programs; and Healthy Families Program		87
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$4,000 (PPO) or \$6,000 (PPO/Non-PPO) per contract per year; some costs do not count toward this protection	19-20

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2005

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

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

Basic Option does not provide benefits when you use Non-preferred providers. For a list of the exceptions to this requirement, see page 12. There is no deductible for Basic Option.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	PPO: \$20 per office visit for primary care physicians and other health care professionals; \$30 per office visit for specialists Non-PPO: You pay all charges	25-28
Services provided by a hospital: • Inpatient • Outpatient.....	PPO: \$100 per day up to \$500 per admission Non-PPO: You pay all charges PPO: \$40 per day per facility Non-PPO: You pay all charges	57-60 61-63
Emergency benefits: • Accidental injury..... • Medical emergency	PPO: \$50 copayment for emergency room care; \$30 copayment for urgent care Non-PPO: \$50 copayment for emergency room care Same as for accidental injury	67-69 70
Mental health and substance abuse treatment.....	In-Network (PPO): Regular cost sharing, such as \$20 office visit copayment (prior approval required); \$100 per day up to \$500 per inpatient admission Out-of-Network (Non-PPO): You pay all charges	72-78
Prescription drugs.....	Retail Pharmacy Program: • PPO: \$10 generic/\$25 formulary brand-name per prescription/50% coinsurance (\$35 minimum) for non-formulary brand-name drugs. 34-day maximum supply on initial prescription; up to 90 days for refills with 3 copayments • Non-PPO: You pay all charges	79-86
Dental care.....	PPO: \$20 copayment per evaluation (exam, cleaning, and x-rays); most services limited to 2 per year; sealants for children up to age 16; \$20 copayment for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	49, 88-89, 93
Special features: Flexible benefits option; online customer and claims service; 24-hour nurse line; services for deaf and hearing impaired; Web accessibility for the visually impaired; travel benefit/services overseas; health support programs; and Healthy Families Program		87
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$5,000 (PPO) per contract per year; some costs do not count toward this protection	19-20

2005 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Standard Option Self Only	104	\$131.08	\$50.71	\$284.01	\$109.87	\$154.74	\$27.05
Standard Option Self and Family	105	\$298.23	\$118.06	\$646.17	\$255.79	\$352.08	\$64.21
Basic Option Self Only	111	\$113.99	\$37.99	\$246.97	\$82.32	\$134.88	\$17.10
Basic Option Self and Family	112	\$266.99	\$88.99	\$578.47	\$192.82	\$315.93	\$40.05