

Carolina Care Plan[®], Inc.

<http://www.carolinacareplan.com>

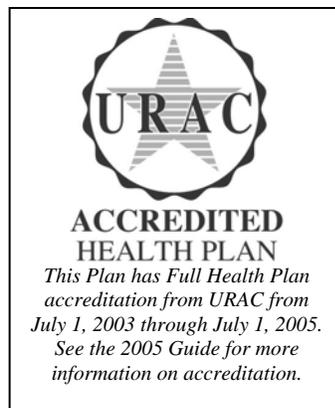


2005

A Health Maintenance Organization

Serving: *The entire state of South Carolina*

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 8 for requirements.



Enrollment code for this Plan:

IB1 Self Only

IB2 Self and Family

Special notice: This Plan is offered for the first time under the Federal Employees Health Benefits Program during the 2004 Open Season.

Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>



OFFICE OF THE DIRECTOR

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

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 19, 2003.

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Introduction

This brochure describes the benefits of Carolina Care Plan[®], Inc. under our contract (CS 2897) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Carolina Care Plan's administrative offices is:

Carolina Care Plan
201 Executive Center Drive
Columbia, SC 29210

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits.

OPM negotiates benefits and rates with each plan annually. Rates are shown at the end 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 Carolina Care 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 that 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 800-868-6734 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 tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

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

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

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

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

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

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

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

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

How we pay providers

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

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. 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.

The mission of Carolina Care Plan is to deliver quality, accessible, affordable, user-friendly health care choices in South Carolina. Carolina Care Plan is one of the largest health maintenance organizations (HMOs) in South Carolina. Carolina Care Plan, formerly known as Physicians Health Plan® Inc., was founded in 1984, and became for-profit in 1996. The majority of members of the board of directors are physicians. In 2003, the Utilization Review and Accreditation Commission (URAC) awarded Full Health Plan Accreditation to the organization. Currently, the plan serves approximately 72,000 members in the state.

As a Carolina Care Plan member, you have certain rights. It is important that you fully understand these rights and responsibilities which are listed here for your information.

You have the right to be treated with respect, dignity and concern for your privacy.

Information concerning medical treatments, procedures or tests you receive or consider receiving, and your personal data will be treated confidentially in compliance with all South Carolina and Federal laws.

You are entitled to pertinent information about Carolina Care Plan, or staff, and your rights and responsibilities as a Carolina Care Plan member.

You have the right to information about the professional qualifications of plan providers.

You are free to discuss all treatment options with our participating providers, whether they are covered benefits or not and regardless of cost.

You are entitled to participate with practitioners in deciding on any planned treatment or tests. Your healthcare provider must obtain an informed consent from you or your family for all treatments, unless there is a life and death emergency. You have the right to spell out in advance (in an "advance directive") what kind of care you would wish to receive if you became unable to express yourself.

You have the right to a second opinion at any time.

You have the right to express complaints about services or care provided, and to appeal our coverage decisions. We will review your concerns. And respond in a timely manner.

If you want more information about us, call 800-868-6734, or write to Carolina Care Plan, Customer Relations, 201 Executive Center Drive, Columbia, South Carolina, 29210, or visit our website at www.carolinacareplan.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area includes all counties within the state of South Carolina.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. We are a new plan

This Plan is new to the FEHB Program. We are being offered for the first time during the 2004 open season.

Section 3. How you get care

Identification cards

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

If you do not receive your ID cards within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-868-6734 or write to us at 201 Executive Center Drive, Columbia, SC 29210. You may also request replacement cards through our Web site at www.carolinacareplan.com.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and/or coinsurance, and you will not have to file claims.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The most current list is also on our Web site, www.carolinacareplan.com.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The most current list available is also on our Web site, www.carolinacareplan.com.

What you must do to get covered care

- **Primary care**

You do not have to choose a primary care physician. You can choose from any plan provider. **It is your responsibility to verify the provider status with the plan when arranging for health care services.** Although we do not require you to select a primary care physician, we recommend that you build a relationship with a primary physician. This helps your doctor to get to know you, your family, and your health history.

- **Specialty care**

You do not need a referral from a primary care physician to receive care from a specialist. You can choose from any Plan provider. It is your responsibility to verify the provider status with the plan when arranging for health care services.

Here are some other things you should know about specialty care:

- If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, consult your provider directory or call your primary care physician. We will notify you at least 30 days in advance of the specialist leaving the plan so you can make arrangements to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist other than for cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan,

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-868-6734. If you are new to the FEHB Program, we will arrange for you to receive care.

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 Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

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

Services requiring our prior approval

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

accepted medical practice.

We call this review and approval process prior notification. Your physician must notify us for specific services, such as:

- Inpatient admissions
- Home health care
- Hospice care
- Dialysis
- Skilled nursing
- Accidental dental
- Blepharoplasty
- Breast reduction
- Breast reconstruction
- Ligation, vein stripping
- Septoplasty
- Durable medical equipment greater than \$1000
- End stage renal disease services
- Organ and tissue transplants
- Prescription drugs, if indicated on the Preferred Drug List
- Growth Hormone Therapy
- Prosthetics/Orthotics
- Self Injectables
- Home Infusion
- Gastric Bypass Surgery
- Mental Health/Substance Abuse
- Genetic Testing
- Oral and maxillofacial surgery

Failure to notify Carolina Care Plan for the above services will result in the denial of the service.

Section 4. Your costs for covered services

You must share the costs of some services. You are responsible for:

Copayments

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

Example: When you see your primary care physician you pay a copayment of \$20 per office visit and when you go in the hospital, you pay \$250 per admission.

Deductible

We do not have a deductible.

Coinsurance

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

Example: In our Plan, you pay 50% of our allowance for infertility services and 30% for durable medical equipment and orthopedic/prosthetics.

Your catastrophic protection out-of-pocket maximum

After your copayments and/or coinsurance total \$2000 per person or \$6000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments and/or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and/or coinsurance for these services:

- *Prescription drugs, including injectable medications*
- *Durable medical equipment*
- *Orthopedic and prosthetic devices*
- *Vision services*
- *Mental health/substance abuse services*
- *Any non-FEHB benefits*

Be sure to keep accurate records of your copayments and/or coinsurance since you are responsible for informing us when you reach the maximum.

Section 5. Benefits – OVERVIEW

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 800-868-6734 or at our Web site at www.carolinacareplan.com.

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

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

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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician's office 	\$20 per visit to a primary care physician. \$30 per visit to a specialist.
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion 	\$20 per visit to a primary care physician. \$30 per visit to a specialist.
At home	\$20 per visit from a primary care physician. \$30 per visit from a specialist.

Lab, X-ray and other diagnostic tests	
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG • TB Tine Test 	<p>Nothing if you receive these services during your office visit; otherwise, \$20 per office visit to a primary care physician or \$30 per visit to a specialist.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Tests received from a non-plan lab even if referred by a Plan provider 	<p><i>All charges.</i></p>
Preventive care, adult	
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol • Routine pap test • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 – Double contrast barium enema – every five years starting at age 50 – Colonoscopy screening – every ten years starting at age 50 • Routine immunizations, limited to: <ul style="list-style-type: none"> – Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) – Influenza vaccine, annually – Pneumococcal vaccine, age 65 and older <p>Note: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i>, above.</p>	<p>\$20 per visit to a primary care physician. \$30 per visit to a specialist.</p>

Preventative care, adult - continued on next page

Preventive care, adult <i>(continued)</i>	
<ul style="list-style-type: none"> • Routine mammogram 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment,</i> • <i>Physical exams required for insurance purposes,</i> • <i>Physical exams required for attending schools or camp,</i> • <i>Physical exams required for purposes of travel,</i> • <i>TB Tine Test (see Lab, X-ray, and other diagnostic tests), or</i> • <i>Exams or testing conducted for purposes of medical research.</i> 	<i>All charges.</i>
Preventive care, children	You pay
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing.
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> – Eye exams through age 17 to determine the need for vision correction – Ear exams through age 17 to determine the need for hearing correction – Examinations done on the day of immunizations (up to age 22) 	\$20 per visit to a primary care physician. \$30 per visit to a specialist.

Maternity care	You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • Prior notification is not required for your normal delivery; see page 29 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	<p>\$30 per office visit. Nothing for complete maternity care after the first visit.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Routine sonograms to determine fetal age, size or sex • Surrogate parenting. 	<p><i>All charges.</i></p>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$20 per visit to a primary care physician. \$30 per visit to a specialist per office visit.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Reversal of voluntary surgical sterilization • Genetic counseling 	<p><i>All charges.</i></p>

Infertility services	You pay
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> – <i>intravaginal insemination (IVI)</i> – <i>intracervical insemination (ICI)</i> – <i>intrauterine insemination (IUI)</i> • Fertility drugs <p>Note: We cover injectable fertility drugs under medical benefits when obtained through the Pharmacy Network Designee for specialty injectable medications and oral fertility drugs under the prescription drug benefit.</p>	<p>\$30 per office visit.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>in vitro fertilization</i> – <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Estrogen or testosterone implants</i> 	<p><i>All charges.</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>\$30 per office visit. \$10 per injection.</p>
<p>Allergy serum</p>	<p>Nothing.</p>
<p><i>Not covered:</i></p> <p><i>Provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges.</i></p>

Treatment therapies	You pay
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 27.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit and must be obtained through the Pharmacy Network Designee for specialty injectable medications.</p> <p>Note: Prior notification is required for growth hormone therapy. To notify us, call 800-868-6734. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies.</p> <p>Note: Prior notification is also required for dialysis. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>\$30 per office visit.</p>
Physical and occupational therapies	You pay
<ul style="list-style-type: none"> • 60 visits per condition per year for the services of each of the following: <ul style="list-style-type: none"> – qualified physical therapists and – occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p>	<p>\$30 per office visit.</p> <p>\$30 per outpatient visit.</p> <p>Nothing per visit during covered inpatient admission.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs • Cardiac rehabilitation • Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. 	<p><i>All charges.</i></p>
Speech therapy	
<p>60 visits per condition per year.</p>	<p>\$30 per office visit.</p> <p>\$30 per outpatient visit.</p> <p>Nothing per visit during covered inpatient admission.</p>

Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	\$30 per office visit.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • All other hearing testing • Hearing aids, testing and examinations for them 	<i>All charges.</i>
Vision services (testing, treatment, and supplies)	You pay
<p>Routine Eye Care Services</p> <ul style="list-style-type: none"> • One refraction exam to detect vision impairment as needed each benefit year. <p>Professional Services for Medical and Surgical Care</p> <ul style="list-style-type: none"> • Services received in a physician’s office • Services received in an inpatient or outpatient facility. <p>Note: You must use Plan’s Well-Vision Network Designee. Contact information is located on the back of your medical ID card.</p>	\$30 per office visit.
<p>Note: See Preventive care, children for eye exams for children.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Eyeglasses or contact lenses • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery • Fitting charge for eyeglasses or contact lenses. 	<i>All charges.</i>
Foot care	
<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>	\$30 per office visit.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • 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 • Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery) • Hygienic and preventative maintenance foot care, such as, cleaning and soaking of the feet and applying skin creams to maintain skin tone. 	<i>All charges.</i>

Orthopedic and prosthetic devices	You pay
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. <p>Note: Benefits for prosthetic devices are limited to a single purchase (including necessary repair/replacement) of each type of prosthetic device every three calendar years. Surgical bras are limited up to two bras every two years.</p>	30%
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Cochlear implants</i> • <i>Prosthetic replacements provided less than three years after the last one purchased</i> • <i>Devices used to affect performance in sports-related activities</i> • <i>Orthotic appliances that straighten or re-shape a body part (including some types of braces)</i> 	<i>All charges.</i>

Durable medical equipment (DME)	You pay
<p>Medical equipment that meets each of the following criteria:</p> <ul style="list-style-type: none"> • Ordered or provided by a Physician for outpatient use, • Used for medical purposes, • Not consumable or disposable, • The least costly equipment that meets your needs, • Not of use to a person in the absence of a disease or disability <p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds; • Wheelchairs; except motorized wheelchairs • Crutches; • Walkers; • Insulin pumps; • Delivery pumps for tube feedings (including tubing and connectors); • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers, and filters, and personal convenience items are not covered). <p>We provide benefits only for a single purchase (including necessary repair/replacement) of a type of Durable Medical Equipment once every three years.</p> <p>Note: Call us at 800-868-6734 as soon as your Plan physician prescribes this equipment. We must receive prior notification on durable medical equipment that costs more than \$1000.</p>	<p>30%</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Motorized wheelchair;</i> • <i>Customized durable medical equipment</i> • <i>Supplies, equipment and similar incidental services and supplies for personal comfort or services and supplies that are not used for medical reasons, such as, air conditioners, batteries and battery charges, television, and telephone.</i> • <i>Prescribed and non-prescribed medical supplies and disposable supplies, such as, ace bandages, gauze and dressings, and ostomy supplies.</i> • <i>Devices used specifically for safety items.</i> 	<p><i>All charges.</i></p>

Home health services	
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	Nothing.
<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>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative;</i> • <i>Custodial care;</i> • <i>Private duty nursing;</i> • <i>Domiciliary care; or</i> • <i>Rest cures.</i> 	<i>All charges.</i>
Chiropractic	You pay
No Benefit	<i>All Charges.</i>
Alternative treatments	
No Benefit	<i>All Charges.</i>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking Cessation • Diabetes self management <p>Note: See Section 5 (f) for our coverage of smoking cessation drugs.</p>	\$25 per office visit.

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:

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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.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below 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.).
- **WE MUST RECEIVE PRIOR NOTIFICATION FROM YOUR PHYSICIAN FOR SOME SURGICAL PROCEDURES.** Please refer to the prior notification information shown in Section 3 to be sure which services require prior notification and identify which surgeries require prior notification.

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Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) 	<p>\$30 per physician office visit.</p> <p>\$100 per outpatient surgery and procedures.</p> <p>Nothing for inpatient services.</p>

Surgical procedures - continued on next page

Surgical procedures (<i>continued</i>)	You pay
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p> <p>Note: For the surgical treatment of morbid obesity, the member must be personally responsible for maintaining good medical follow-up to ensure proper nutritional assessments, and have previously failed attempts at losing weight using more conservative therapies. These procedures require prior notification. See section 3 for more information.</p>	<p>\$30 per physician office visit.</p> <p>\$100 per outpatient surgery and procedures.</p> <p>Nothing for inpatient services.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> • <i>Cosmetic surgery,</i> • <i>Psychosurgery,</i> • <i>Surgery for excessive sweating, or,</i> • <i>Surgery for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.</i> 	<p><i>All charges.</i></p>

Reconstructive surgery	You pay
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – the condition produced a major effect on the member’s appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – surgery to produce a symmetrical appearance of breasts; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$30 per physician visit for outpatient services.</p> <p>\$100 per outpatient surgery and procedures.</p> <p>Nothing for inpatient services.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges.</i></p>
Oral and maxillofacial surgery	You pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>\$30 per physician visit for outpatient services.</p> <p>\$100 per outpatient surgery and procedures.</p> <p>Nothing for inpatient services.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges.</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • 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>We require that transplants be received at a Plan Designated Facility.</p> <p>We require prior notification for transplants. Please notify us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p> <p>Cornea transplants are covered through the Well-Vision Network Designee. Contact information is located on the back of your medical ID card.</p> <p>We cover some travel expenses for transplants when the services are provided by a Plan Designated Facility, the Designated Facility is more than 100 miles from the patient’s home, we are the primary coverage plan, and we receive notification from you prior to each travel, including follow-up visits. Benefits are limited to \$10,000 per lifetime for travel expenses. Contact us for information.</p>	<p>\$30 per physician visit for outpatient services.</p> <p>\$100 per outpatient surgery and procedures.</p> <p>Nothing for inpatient services.</p>

Organ/tissue transplants – continued on next page

Organ/tissue transplants <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> • <i>Health services connected with the removal of an organ or tissue from you for purposes of transplant to another person.</i> • <i>Transplants that are not performed at a Designated Plan Facility.</i> 	<p><i>All charges.</i></p>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	<p>Nothing</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>\$30 per physician office visit.</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.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN IS REQUIRED TO NOTIFY US PRIOR TO HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require prior notification.

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Benefit Description	You pay
Inpatient hospital	
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	\$250 per admission.

<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> • <i>Comfort or convenience items, including non-prescribed items billed by a hospital for use at home.</i> • <i>Cord blood procurement and storage for possible future need or for a yet-to-be determined member recipient.</i> 	<p><i>All charges.</i></p>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>\$100 per surgery.</p>
<p><i>Not covered: Storage of blood for elective surgery</i></p>	<p><i>All charges.</i></p>
Extended care benefits/Skilled nursing care facility benefits	
<p>Up to 100 days per calendar year when full-time skilled care is necessary and confinement in a skilled nursing facility defined as a hospital or nursing facility that is licensed and operated as required by law. We cover the following:</p> <ul style="list-style-type: none"> • Services and supplies received during the Inpatient stay. • Room and board in a Semi-Private Room (a room with two or more beds). 	<p>You pay</p> <p>Nothing.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Custodial care in an intermediate care facility</i> 	<p><i>All charges.</i></p>

Hospice care	
<p>Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, physiological, social, and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency or facility.</p> <p>Benefits are limited to 180 days during the entire period of time you are covered under the Policy.</p>	Nothing.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing, homemaker services</i> • <i>Respite care</i> 	<i>All charges.</i>
Ambulance	
Local professional ambulance service when ordered or authorized by a Plan physician.	\$75 per trip.

Section 5(d) Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We have no calendar year deductible.

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What is a medical emergency?

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

What to do in case of emergency:

If you have a medical emergency, dial 911 or go to the nearest emergency room.

Emergencies within our service area: Emergency care is provided at plan hospitals 24 hours a day, seven days a week. The location and phone number of your nearest plan hospital may be found in your Provider Directory.

If you think that you have a medical emergency condition and you cannot safely go to a plan hospital, call 911 or go to the nearest hospital. You are not required to notify us for Emergency Health Services. Be sure to tell the emergency room personnel that you are a Plan member so they can notify us if you are admitted.

If you are confined in a non-plan hospital after you receive emergency health services, you must notify us within one business day or the day of admission, unless it is not reasonably possible to notify us within that time. We may elect to transfer you to a plan hospital as soon as it is medically appropriate to do so. If you choose to stay in a non-plan hospital after the date we decide a transfer is medically appropriate, benefits will not be available.

Benefits are paid for emergencies, even if the services are provided by a non-plan provider.

If you are admitted as an inpatient to a plan hospital within 24 hours of receiving treatment for the same condition as an emergency health service, you will not have to pay the copayment for emergency health services. The copayment for the inpatient stay will apply instead.

Note: Please note that the copayment for emergency health services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an inpatient in the hospital. In this case, the emergency copayment will apply instead of the copayment for an inpatient hospitalization.

Emergencies outside our service area: Benefits are available for any medically necessary health service that is immediately required because of injury or an unforeseen illness.

If you need to be hospitalized, you must notify us within one business day or the day of admission, unless it was not reasonably possible to notify us within that time. We may elect to transfer you to a plan hospital as soon as it is medically appropriate to do so. If you choose to stay in a non-plan hospital after the date we decide a transfer is medically appropriate, benefits will not be available.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctors' office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	<p>\$50 per office visit.</p> <p>\$100 per visit</p> <p>\$100 per visit.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Follow up care at a non-plan provider</i> 	<p><i>All charges.</i></p>
Emergency outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctors' office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	<p>\$50 per office visit.</p> <p>\$100 per visit</p> <p>\$100 per visit.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Follow up care at a non-plan provider</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<p><i>All charges.</i></p>
Ambulance	
<p>Professional ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	<p>\$75 per trip.</p>
<p><i>Not covered: Air ambulance</i></p>	<p><i>All charges.</i></p>

Section 5(e) Mental health and substance abuse benefits

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When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE BENEFITS.** See the instructions after the benefits description below.

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Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	\$30 per visit.
<ul style="list-style-type: none"> • Diagnostic tests 	\$30 per (visit or test).
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, full-day hospitalization, facility based intensive outpatient treatment. 	\$250 per admission
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services we have not approved</i> <p><i>Note: 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.</i></p>	<i>All charges.</i>

Prior Authorization To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes:

Contact the Mental Health/Substance Abuse Designee at 800-877-6003 for Prior authorization, locating providers, and questions about your mental health/substance abuse benefits.

Limitation We may limit your benefits if you do not obtain a treatment plan.

Section 5(f) Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician or nurse practitioner must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan retail pharmacy, or by a mail order pharmacy for maintenance medication. Some specialty and self-administered injectable medications, except for Imitrex and insulin, must be obtained through the Pharmacy Network Designee.
- **We use a formulary.** Carolina Care Plan's Preferred Drug List (PDL) is a 3-tier benefit design (generic/preferred brand/non-preferred brand). It is designed to provide a broad therapeutic list of preferred drugs for use in meeting the pharmacy needs of our members. It is intended to serve as a guide in selecting clinically and therapeutically appropriate medication in a cost-effective manner. Carolina Care Plan's Preferred Drug List is not intended to take the place of a physician's judgment with regard to their patient's pharmaceutical care. Each physician/practitioner must rely on his/her own best medical judgment in selecting appropriate pharmaceutical agents. The list provides examples of drugs but it not an exhaustive list of all drugs falling into each benefit category. The Preferred Drug List was developed by Carolina Care Plans' Pharmacy and Therapeutics (P&T) Committee. This Committee is composed of plan physicians and pharmacists. Drugs included on the PDL were selected as a result of thorough analysis against relevant clinical criteria. Clinical/therapeutic superiority outweighs cost considerations in all decisions.

- **These are the dispensing limitations.** The following dispensing limitations apply for prescriptions dispensed by a retail plan pharmacy:

Up to 31-day supply, unless adjusted based on the drug manufacturer's packaging size, or based on quantity limits. You may obtain between a 32-day supply and 60-day supply for two times the applicable copayment.

A one-cycle supply of oral contraceptive. You may obtain up to three cycles at one time if you pay a copayment for each cycle supplied.

The following dispensing limitations apply for prescriptions dispensed by a mail service plan pharmacy:

Up to a consecutive 90-day supply of a prescription, unless adjusted based on the drug manufacturer's packaging size, or based on quantity limits. To receive the maximum benefit, your provider must write your prescription order or refill for the full 90 days.

A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand preferred and name brand non-preferred drug and the generic.

Prescription drug benefits begin on the next page

Prescription drugs (*continued*)

Why use generic drugs? Carolina Care advocates the use of generic drugs. Generic drugs are basically copies of the brand name version and are deemed to be safe and effective by the FDA. Generic drugs are less expensive because generic manufacturers don't have the investment costs of the developer of a new drug. Today, almost half of all prescriptions are filled with generic drugs.

Members may be required to pay a higher copayment or the entire cost of the prescription when a non-preferred brand-name product is dispensed. Note that if a brand-name drug becomes available as a generic during the year, that brand-name product may become non-preferred. The member's copayment is determined by their prescription drug benefit plan. When generic substitution conflicts with state regulations or restrictions, the pharmacist must obtain approval from the prescriber to use the generic equivalent.

When you do have to file a claim. We pay network pharmacies directly for your covered prescription when they send the claim electronically to our Network Pharmacy Designee. You are responsible for paying your copayment.

If the Network Pharmacy is unable to electronically send the prescription claim to our Plan Pharmacy Benefit Manager, you will be required to pay the pharmacy for the prescription at the time it is dispensed. You may then submit a claim for reimbursement to our Plan Pharmacy Benefit Manager. You can obtain a prescription drug claim form by calling the customer service number on either your medical or pharmacy ID card. Follow all instructions on the form and mail it with the prescription receipt, not the cash register receipt, to the address provided on the form.

The amount reimbursed will be based on the Predominant Drug Rate, less the required Copayment that applies. Claims must be submitted by December 31 of the year after the year service was received, unless timely filing was prevented by administrative operations of the Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

If you receive a covered prescription from a non-plan pharmacy, except in an emergency situation, you are responsible for the entire cost.

Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase except those listed as <i>Not covered</i>. • Insulin • Disposable needles and syringes for the administration of covered medications • Standard blood glucose monitors • Spacers for inhalers • Drugs for sexual dysfunction • Contraceptive drugs • Smoking cessation products are covered through the plan retail pharmacy network and are limited to three prescriptions per calendar year. • Treatment of onychomycosis using Lamisil tablets or Sporanox capsules/syrup is limited to 90 days of therapy per calendar year. • Oral fertility drugs • Growth hormone <p>Note: Additional months supply of prescriptions can be received in times of emergency or prolonged travel.</p> <p>Drugs that require prior notification are designated in the Preferred Drug List (PDL).</p>	<p><u>Plan Retail Pharmacy:</u></p> <p>\$10 per generic prescription \$20 per preferred brand name prescription \$50 per non-preferred brand name prescription</p> <p><u>Mail-Order Program for Maintenance Medications</u></p> <p>\$20 per generic prescription \$40 per preferred brand name prescription \$100 per non-preferred brand name prescription</p> <p>Note: If there is no generic equivalent available, you will still have to pay the preferred or non-preferred brand name copay.</p> <p><u>Fertility and growth hormone drugs</u></p> <p>50%</p>

Not covered:

- *Drugs and supplies for cosmetic purposes*
- *Drugs to enhance athletic performance*
- *Drugs obtained at a non-Plan pharmacy*
- *Vitamins, nutrients and food supplements even if a physician prescribes or administers them*
- *Nonprescription medicines*
- *Drugs that exceed the amount dispensed quantity limit, except when medically necessary*
- *Medications used for experimental indications and/or dosage regimens determined to be experimental.*
- *Drugs furnished by the local, state, or federal government.*
- *Compound drug products that do not contain at least one ingredient that requires a prescription order or refill or do not otherwise qualify for coverage.*
- *Prescribed and non-prescribed outpatient supplies, other than diabetic supplies and inhaler spacers specifically stated as covered.*
- *Replacement drugs resulting from a lost, stolen, broken, or destroyed prescription order or refill.*
- *Estrogen, Progestin, Prostaglandin and Testosterone injections and pellets.*
- *Drugs available without a prescription or for which there is a nonprescription equivalent available.*
- *General and injectable vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins and vitamins with fluoride, and single entity vitamins.*
- *Unit dose packaging of Prescription Drug Products*

All charges.

Section 5(g) Special features

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 coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative 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.
24 hour nurse line	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 800-262-5155 and talk with a registered nurse who will discuss treatment options and answer your health questions.</p>
Care management programs	<p>The following programs are offered through Carolina Care Plan and include phone counseling with a registered nurse, educational mailings, and communication with a physician.</p> <ul style="list-style-type: none"> • Adult & Pediatric Asthma • Cardiovascular Programs: Congestive Heart Failure & Ischemic Heart Disease • Diabetes <p>Call 800-868-6734 to sign up.</p>
Baby Steps	<p>Includes confidential pregnancy screens, educational materials tailored for specific needs, and 24-hour telephone access to an experienced obstetrical nurse from program enrollment up to six weeks after delivery.</p> <p>Call 800-868-6734 to sign up.</p>
High risk pregnancies	<p>Strives to bring high-risk pregnancies closer to term and decrease neonatal intensive care unit stays. Helps to manage infants with complex needs due to premature birth and/or congenital abnormalities. Includes nurse specialists who can help with risk screenings, coordinating care, and education.</p> <p>Call 800-868-6734 for more information.</p>

Wellness Programs

- **Hypertension & Cholesterol Program**

Learn through educational materials how diet, exercise and the medication prescribed by a physician can help make a positive difference in your health.

- **Hepatitis C *Be In Charge* Program**

A free and confidential program for members who have recently started one of the therapies from Schering Oncology-Biotech. Includes information and education, emotional support, and monthly calls from nurse counselors.

Call 800-868-6734 to find out more.

Section 5(h) Dental benefits

Here are some important things to 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
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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Accidental injury benefit	You pay
<p>We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.</p> <p><i>Note:</i> We require prior notification for this benefit. See Section 3 for information.</p>	<p>\$20 per primary care physician office visit</p> <p>\$30 per specialist office visit.</p> <p>\$250 per inpatient admission.</p> <p>\$100 per outpatient procedure.</p>

Dental benefits

We have no other dental benefits.

Section 5(i) Non-FEHB Benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

Alternative Medicine

As a member of Carolina Care Plan, you are eligible for the Carolina Alternative ChoicesSM program. This program is a discount program for **alternative medicine services** through the American WholeHealth Network (AWHN). Discounted services include: chiropractic, massage/body work, exercise/movement specialties, acupuncture, nutrition, and relaxation techniques. Members also have access to website link through carolinacareplan.com that includes recipes, a reference library, news, vitamin and supplement information, and recommended “healing paths” organized by condition.

Note: This is a discount program and is not part of your FEHP benefits. The discount program is available to enrollees and family members who are members of Carolina Care Plan. For more information about Carolina Alternative Choices, contact 800-274-7526 or access www.carolinacareplan.com.

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 your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- 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 or psychiatric practice;
- 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;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service;
- Services performed by a provider who is a family member or performed by a provider with your same legal residence;
- Services, drugs, or supplies for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers compensation, no-fault auto insurance, or similar legislation;
- Services, drugs, or supplies for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the policy;
- Services not specifically listed as covered.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 800-868-6734.

When you must file a claim – such as for services you receive outside of the Plan’s service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to: P.O. Box 100234, Columbia, SC 29202-3234

Note: Handwritten and altered claims are not accepted.

Prescription drugs

When you must file a claim – You can obtain a prescription drug claim form by calling the customer service number on either your medical or pharmacy ID card. Follow all instructions on the form and mail it with the prescription receipt, not the cash register receipt.

Submit your claims to: Express Scripts, Inc., ATTN: Claims Department, P.O. Box 390873, Bloomington, MN 55439-0873.

Deadline for filing your claim

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

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 prior approval:

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: Carolina Care Plan, 201 Executive Center Drive, Columbia, SC 29210; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude 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> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk 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; or120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none">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; andYour daytime phone number and the best time to call. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>

The disputed claims process (*continued*)

Note: You are the only person who has a right to file a disputed claim with OPM, and 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 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 claim 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 haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800-868-6734 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/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 2 at 202/606-3818 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 have 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.

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.

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 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 the 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 Original Medicare, 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.

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 Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 800-868-6734 or see our Web site at www.carolinacareplan.com.

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

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... You have FEHB coverage on your own or through your spouse who is also an active employee		✓
5) 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... • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• 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. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments or coinsurance. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

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 the program.

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

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
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 12.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Services that are non-health related, such as assistance in activities of daily living (including, but not limited to feeding, dressing, bathing, transferring, and ambulating; or health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing.
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 those services. See page 12.
Experimental or investigational services	<p>Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:</p> <ul style="list-style-type: none">• Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.• Subject to review and approval by any institutional review board for the proposed use.• The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.• Rated with a C or lesser rating with the Hayes Rating System. <p>If you have a life-threatening illness or condition (one of which likely to cause death within one year of the request for treatment) we may, in our discretion, determine that an Experimental or Investigational service is a covered benefit. For this to take place, we must determine that the procedure or treatment is promising, but unproven, and the service uses a specific research protocol that meets standards equivalent to those defined by the National Institute of Health.</p>
Group health coverage	Health care benefits that are available as a result of your employment, or the employment of your spouse, and that are offered by an employer or through membership in an organization. Health care coverage may be insured or indemnity coverage, self-insured or self-funded coverage, coverage through health maintenance organizations or other managed care plans. Health care coverage purchased through membership in an organization is also “group health coverage”.
Medical Necessity	<p>Medical Necessity – Services, drugs, supplies, or equipment provided by a hospital or covered provider of health care services that the Plan determines:</p> <ul style="list-style-type: none">• are appropriate to diagnose or treat the patient’s condition, illness, or injury;• are consistent with national standards of medical practice;

- are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
- are not a part of or associated with the scholastic education or vocational training of the patient;
- in the case of inpatient care, cannot be provided safely on an outpatient basis;
- is consistent with conclusions of prevailing medical research that demonstrate that the service, drug, supply, or equipment has a beneficial effect on health outcomes and are based on well conducted randomized controlled trials or cohort studies.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically necessary or covered by this plan. Decisions about whether to cover new technologies, procedures, and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: Your coinsurance is based on our contracted fee(s) with the provider. If you receive services from a non-plan provider, your coinsurance is based upon the fee(s) we negotiate with the non-plan provider or the Reasonable and Customary charge which is representative of the average and prevailing charge for the same health service in that geographic area as determined by us. The allowance must not be greater than the fees that the Provider would charge any other payor in the same or similar situation for the same services.

Predominant Drug Rate

The amount we will pay to reimburse using our Prescription Drug Cost that applies for that particular Drug Cost at most Network pharmacies.

Us/We

Us and We refer to Carolina Care Plan.

You

You refers to the enrollee 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. 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 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 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 2003 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.

- **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 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; 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 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 tax-free 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 amount that can be allotted for the HCFSA is \$4,000 annually. *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 a 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 signed on to participate. Under IRS law, FSAs are not available to annuitants. In addition, 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 at www.FSAFEDS.com will help you plan your FSA.

- **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 page 66 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 is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under this Plan, typical out-of-pocket expenses include: copayments for inpatient hospital stays, prescription drug copayments, and coinsurance for DME. Other out-of-pocket expenses include amounts that you pay for chiropractic and dental benefits and alternative treatment therapies.

The IRS governs expenses reimbursable by a 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 a FSAFEDS Benefit 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 which 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.

- **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 9:00 a.m. until 9:00 p.m. Eastern Time.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877-FSAFEDS (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.

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Anesthesia	5	Family planning	19	Prescription drugs	21, 47, 53, 66
Autologous bone marrow transplant	21, 29	Fecal occult blood test	17	Preventive care, adult	17
Biopsy	26	Fraud	3, 4	Preventive care, children	18
Blood and blood plasma	32	General exclusions	14	Prior approval	48, 49
Casts	31, 32	Hearing services	22	Prosthetic devices	23, 27
Catastrophic protection out-of-pocket maximum	13, 45, 66	Hospital	5, 6, 7, 10, 11, 24, 26, 27, 28, 29, 30, 31, 32, 35, 36, 44, 47, 50, 53, 54, 66	Psychologist	36
Chemotherapy	21	Infertility	13, 20	Radiation therapy	21
Cholesterol tests	17	Inpatient hospital benefits	47	Room and board	31
Claims	10, 14, 47, 48, 52, 58, 61	Mammograms	17	Second surgical opinion	16
Coinurance	7, 10, 13, 47, 53, 55, 62	Maternity benefits	19	Smoking cessation	25
Colorectal cancer screening	17	Medicaid	53	Social worker	36
Congenital anomalies	26, 28	Medically necessary	16, 19, 24, 26, 31, 34, 36, 38, 44	Splints	31
Contraceptive drugs and devices	19, 40	Medicare	36, 50, 52	Subrogation	54
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Crutches	24	Original	50, 53	Surgery	5, 19, 23, 27
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Disputed claims review	42	Non-FEHB benefits	45	Syringes	40
Donor expenses	29	Nurse		Transplants	21, 29
Dressings	31	Nurse Anesthetist (NA)	31	Treatment therapies	21
Durable medical equipment	24	Office visits	7, 13	Wheelchairs	24
		Oral and maxillofacial surgical	28	Workers' Compensation	53
		Out-of-pocket expenses	50, 62	X-rays	17, 31, 32

Summary of benefits for Carolina Care Plan - 2005

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: \$20 primary care; \$30 specialist	16
Services provided by a hospital: • Inpatient	\$250 per admission copay	31
• Outpatient	\$100 per surgery	32
Emergency benefits • In area and out-of-area.....	\$50 per office visit, \$100 per urgent care, outpatient, or inpatient at hospital.	34
Mental health and substance abuse treatment	Regular cost sharing	36
Prescription drugs	Retail plan pharmacy: \$10 for generic prescription \$20 per preferred brand name prescription \$50 per non-preferred brand name prescription Mail order program: \$20 for generic prescription \$40 for preferred brand name prescription \$50 for non-preferred brand name prescription	40
Dental care	No benefit.	44
Vision Care	\$30 per office visit	22
Special features: 24 Hour Nurse Line Care Management Programs Baby Steps High Risk Pregnancy Programs Wellness Programs		42
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$2000/Self Only or \$6000/Family enrollment per year Some costs do not count toward this protection	13

2005 Rate Information for California Care Plan

Non-Postal rates apply to most non-Postal employees. 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.

		Non-Postal Premium				Postal Premium	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	IB1	\$130.49	\$ 43.50	\$282.74	\$ 94.24	\$154.42	\$ 19.57
Self & Family	IB2	\$293.51	\$ 97.84	\$635.95	\$211.98	\$347.32	\$ 44.03