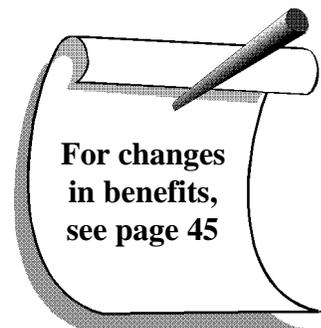




BACE Health Benefit Plan

1998

**A Managed Fee-For-Service Plan
with a Preferred Provider Organization;
a Point Of Service Product**



Sponsored by : The Beneficial Association of Capitol Employees

Who may enroll in this Plan: To enroll in this plan you must be, or must become, a member of the Beneficial Association of Capitol Employees.

To become a member: To be eligible for membership in the Association you must be an employee of the U.S. Senate, U.S. House of Representatives, the General Accounting Office, the Government Printing Office, the Library of Congress or the Architect of the Capitol.

Annuitants (retirees) may enroll in this Plan if they were members of the Association before retirement and continued membership in the Association after retirements.

Membership dues: \$25.00 per year. New members will be billed separately for annual dues when the Plan receives notice of enrollment. Continuing members will be billed by the Plan for the annual membership.

Enrollment Code for this Plan:

YD1	Self Only
YD2	Self and Family

Authorized for distribution by the:



United
States
Office of
Personnel
Management



Federal Employees
Health Benefits Program

R1 72-008

Authorized for distribution by the:



United
States
Office of
Personnel
Management



1998 Rate Information for BACE Health Benefit Plan

FEHB Benefits of this Plan are described in brochure 72-008.

The 1998 rates for this Plan follow. **Non-Postal rates** apply to most non-Postal enrollees. If you are in a special enrollment category, refer to an FEHB Guide or contact the agency that maintains your health benefits enrollment.

Type of enrollment	Enrollment code	<u>Biweekly premium</u>		<u>Monthly Premium</u>	
		Gov't share	Your share	Gov't share	Your share
Self Only	YD1	\$ 61.61	\$20.53	\$133.48	\$44.49
Self and Family	YD2	\$142.27	\$54.85	\$308.25	\$118.84

The Beneficial Association of Capitol Employees

The Beneficial Association of Capitol Employees (BACE) has entered into Contract No. CS 2113 with the Office of Personnel Management (OPM) to provide a health benefits plan authorized by the Federal Employees Health Benefits (FEHB) law. The Plan is underwritten by Optimum Choice, Inc. and MAMSI Life and Health, Inc. which administers this Plan on behalf of the Carrier and is referred to as Carrier in this brochure. The FEHB contract specifies the manner in which it may be modified or terminated.

This brochure is based on text incorporated into the contract between OPM and the Carrier as of January 1, 1998 and is intended to be a complete statement of benefits available to FEHB members. It describes the benefits, exclusions, limitations, and maximums of the BACE Health Benefit Plan for 1998 and until amended by future benefit negotiations between OPM and the Carrier. It also describes procedures for obtaining benefits. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. Oral statements cannot modify the benefits described in this brochure.

An enrollee does not have a vested right to receive the benefits in this brochure in 1999 or later years, and does not have a right to benefits available prior to 1998 unless those benefits are contained in this brochure.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD which may result in CRIMINAL PENALTIES.

Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital, pharmacy, etc., charged your Plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider (doctor, hospital, etc.) and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Carrier at 301-881-0510 and explain the situation
- If the matter is not resolved after speaking to your Carrier (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE

202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C., 20415

The inappropriate use of membership identification cards, e.g., to obtain benefits for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

When you need help with Plan Benefits, or getting your ID card, call the Plan at (301) 881-0510 or Member Services at (800) 605-8202 / (301) 294-3777. The Fraud Hotline cannot help you with these.

Using This Brochure

The Table of Contents will help you find the information you need to make the best use of your benefits. To get the best value for your money, you should read **Facilities and Other Providers**. It will help you understand how your choice of doctors and hospitals will affect how much you pay for services under this Plan.

This brochure explains all of your benefits. It's important that you read about your benefits so you will know what to expect when a claim is filed. Most of the benefit headings are self-explanatory. **Other Medical Benefits** and **Additional Benefits**, on the other hand, both include a variety of unrelated benefits. What is different about these benefits is how they are paid: Other Medical Benefits are paid after you satisfy the calendar year deductible and Additional Benefits are generally not subject to the calendar year deductible.

You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on which provider bills for the service. For example, physical therapy is paid one way if it is billed by an inpatient facility and paid another way when it is billed by a doctor, physical therapist or outpatient facility.

The last part of the brochure contains information useful to you under certain circumstances. For example, if you have to go to the hospital you need to read **Precertification**; hospital stays **must** be precertified for all payable benefits to apply. If you are enrolled in Medicare, take a look at **This Plan and Medicare**. And, the **Enrollment Information** section tells you about several FEHB enrollment requirements that could affect your future coverage.

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How This Plan Works

Help Contain Costs

You can help

FEHB plans are expected to manage their costs prudently. All FEHB plans have cost containment measures in place. All fee-for-service plans include two specific provisions in their benefits packages: precertification of all inpatient admissions and the flexible benefits option. Some include managed care options, such as PPO's, to help contain costs.

As a result of your cooperative efforts, the FEHB Program has been able to control premium costs. Please keep up the good work and continue to help keep costs down.

Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with Optimum Choice, Inc., before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by \$500. Be a responsible consumer. Be aware of your Plan's cost containment provisions. You can avoid penalties and help keep premiums under control by following the procedures specified on page 34 of this brochure.

Flexible benefits option

Under the flexible benefits option, the Carrier has the authority to determine the most effective way to provide services. The Carrier may identify medically appropriate alternatives to traditional care and coordinate the provision of Plan benefits as a less costly alternative benefit. Alternative benefits are subject to ongoing review. The Carrier may decide to resume regular contract benefits at its sole discretion. Approval of an alternative benefit is not a guarantee of any future alternative benefits. The decision to offer an alternative benefit is solely the Carrier's and may be withdrawn at any time. It is not subject to OPM review under the disputed claims process.

Optimum Choice PPO

This Plan offers most of its members the opportunity to reduce out-of-pocket expenses by choosing providers who participate in the Plan's preferred provider organization (PPO). Consider the PPO cost savings when you review Plan benefits and check with the Carrier to see whether PPO providers are available in your area.

Facilities and Other Providers

Covered facilities

Hospice

A facility that provides short periods of stay for a terminally ill person in a home-like setting for either direct care or respite. This facility may be either free-standing or affiliated with a hospital. It must operate as an integral part of the hospice care program.

Hospital

An institution licensed as a hospital by the State or conforming to the standards of and accredited by the Joint Commission on Accreditation of Healthcare Organizations providing inpatient diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of licensed doctors of medicine (M.D.) or licensed doctors of osteopathy (D.O.). The hospital must provide continuous 24-hour-a-day professional registered nursing (R.N.) services and may not be an extended care facility (other than an approved ECF); nursing home; a place of rest; an institution for exceptional children, the aged, drug addicts, or alcoholics; or a custodial or domiciliary institution having the primary purpose of furnishing food, shelter, training, or non-medical personal services. This definition includes college infirmaries and Veterans Administration Hospitals.

Skilled nursing facility

An institution or that part of an institution which provides skilled nursing care 24 hours-a-day and is classified as a skilled nursing facility under Medicare.

Facilities and Other Providers *continued*

Covered providers

For purposes of this Plan, covered providers include: 1) a licensed doctor of medicine (M.D.); a licensed doctor of osteopathy (D.O.), hereafter referred to as physician; and 2) for certain specified services covered by this Plan, a licensed doctor of podiatry (D.P.M.), a licensed dentist, optometrist, and chiropractor. Other covered providers who may render services without the supervision of an M.D. but for whom the Plan provides benefits include a qualified clinical psychologist, clinical social worker, optometrist, nurse midwife, nurse practitioner/clinical specialist and nursing school administered clinic. For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

Coverage in medically underserved areas

Within States designated as medically underserved areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of that license. For 1998, the States designated as medically underserved are: Alabama, Louisiana, Mississippi, New Mexico, South Carolina, South Dakota, West Virginia and Wyoming.

This Plan's PPO (Optimum Choice)

Benefits under this Plan are available from facilities, such as hospitals, and from providers, such as pharmacies, doctors and other health care personnel, who provide covered services. This Plan covers two types of facilities and providers: (1) those who participate in a preferred provider organization (PPO) and (2) those who do not. Who these health care providers are, and how benefits are paid for their services, are explained below. In general, it works like this.

PPO facilities and providers have agreed to provide services to Plan members at a lower cost than you'd usually pay a non-PPO provider. Although PPO's are not available in all locations or for all services, when you use these providers you help contain health care costs and reduce what you pay out of pocket. The selection of PPO providers is solely the Carrier's responsibility; continued participation of any specific provider cannot be guaranteed.

While PPO providers agree with the Carrier to provide covered services, final decisions about health care are the sole responsibility of the doctor and patient and are independent of the terms of the insurance contract.

PPO benefits apply only when you use a PPO provider. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply.

When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, anesthesiologists and pathologists, may not all be preferred providers. If they are not they will be paid by this Plan as non-PPO providers.

Non-PPO facilities and providers do not have special agreements with the Carrier. The Plan makes its regular payments toward their bills, and you're responsible for any balance.

The Optimum Choice PPO is an arrangement between this Plan's underwriter and physicians, hospitals, health care institutions and other health care professionals to provide medical care to you and your eligible dependents at a predetermined copayment. Providers who belong to the network must meet specific criteria including location, medical specialty, professional skill and proper credentials; however, inclusion in the network does not represent guarantee of professional performance nor does it constitute medical advice. In order to receive benefits under this Optimum Choice PPO, you or your eligible dependents must select a primary care physician. Your primary care physician will coordinate all of your medical care by either providing the care or by referring you or your eligible dependents to a specialist or hospital. This brochure outlines under each benefit category the exact copayment that will be required for each service. The Optimum Choice PPO is available in the Washington-Baltimore and Mid-Atlantic area. You may obtain a listing of providers in your area by calling the BACE Health Benefit Plan at (301) 881-0510 or Member Services' at (800) 605-8202 / (301) 294-3777. The selection of PPO providers is solely the Plan's responsibility; continued participation of any specific PPO provider cannot be guaranteed.

Cost Sharing

Deductibles

A deductible is the amount of expense an individual must incur for covered services and supplies before the Plan starts paying benefits for the expense involved. A deductible is not reimbursable by the Plan and benefits paid by the Plan do not count toward a deductible. When a benefit is subject to a deductible, only expenses allowable under that benefit count toward the deductible.

Calendar year

The calendar year deductible is the amount of expenses an individual must incur for covered services and supplies each calendar year before the Plan pays certain benefits. The deductible is \$250 and is applied once per person in a calendar year regardless of how many different illnesses or accidents a person may have.

Other

In addition to the calendar year deductible, separate deductibles apply to dental (page 28) and to inpatient hospital expenses (pages 12 and 19). There is a \$150 inpatient hospital deductible, per admission, under the Optimum Choice PPO benefits and a \$250 inpatient hospital deductible, per admission, under the non-PPO benefits for Inpatient Hospital Benefits.

Carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible in the prior year will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

Family limit

There is a separate calendar year deductible of \$250 per person. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members (1) after two family members have met their calendar year deductible, or (2) when the combined covered expenses applied to the deductible for all family members reach \$500 during a calendar year.

Common accident

If two or more covered members of your family are injured in the same accident, there is only one \$250 calendar year deductible for those members for all expenses related to the accident.

Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductible. You are required to pay the following coinsurance on benefits under this Plan:

- 30% for inpatient and outpatient surgery;
- 30% for physician and midwife care under Maternity Benefits;
- 30% for Other Medical Benefits;
- 50% for treatment of mental conditions;
- 10% for skilled nursing facility;
- 30% for routine physicals;
- 10% for inpatient hospitalization;
- 30% for well child care; and
- 20% for inpatient treatment for mental conditions.

After you meet any deductible, the coinsurance is the minimum amount you will have to pay. The Plan will base this percentage on either the billed charge or the usual, reasonable and customary charge, whichever is less. For instance, when a Plan pays 80% of reasonable and customary charges for a covered service, you are responsible for the 20% coinsurance. In addition, you may be responsible for any excess charge over the Plan's reasonable and customary allowance. For example, if the provider ordinarily charges \$100 for a service but the Plan's reasonable and customary allowance is \$95, the Plan will pay 80% of the allowance (\$76). You must pay the 20% coinsurance (\$19), plus the difference between the actual charge and the reasonable and customary allowance (\$5), for a total member responsibility of \$24. Remember, if you use Optimum Choice PPO providers, participating physicians and member hospitals, your share of covered charges is limited to a copayment amount of \$10 for a primary care physician or a specialty care physician.

Cost Sharing *continued*

Copayments

A copayment is the stated amount the Plan may require you to pay for a covered service, such as \$10 per prescription by mail or \$10 per office visit charge at a PPO provider.

If provider waives your share

If a provider routinely waives (does not require you to pay) your share of the charge for services rendered, the Plan is not obligated to pay the full percentage of the amount of the provider's original charge it would otherwise have paid. A provider or supplier who routinely waives coinsurance, copayments or deductibles is misstating the actual charge. This practice may be in violation of the law. The Plan will base its percentage on the fee actually charged. For example, if the provider ordinarily charges \$100 for a service but routinely waives the 20% coinsurance, the actual charge is \$80. The Plan will pay \$64 (80% of the actual charge of \$80).

Lifetime maximums

Benefits for substance abuse are limited to \$5,500 for one 30-day inpatient program per calendar year and 2 programs per lifetime for each covered person. Benefits for smoking cessation are limited to one smoking cessation program per lifetime per member.

General Limitations

All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable when determined by the Carrier to be medically necessary. Coverage is provided only for services and supplies that are listed in this brochure. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under the Plan or be used in the prosecution or defense of a claim under the Plan.** This brochure is based on text included in the contract between OPM and this Plan and is intended to be the complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Carrier and complete all necessary documents and authorizations requested by the Carrier.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 36 & 37 apply.

Group health insurance and automobile insurance

Coordination of benefits (double coverage) applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Carrier. When there is 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. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100% of covered expenses. When this plan pays secondary, it will only make up the difference between the primary plan's coverage and this plan's coverage. Thus, combined payments from both plans may not equal the entire amount billed by the provider.

The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Carrier to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first.

General Limitations *continued*

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' Compensation

The Plan will not pay for benefits or services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statute governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

Subrogation applies when you are sick or injured as a result of the act or omission of another person or party. Subrogation means the Plan's right to recover any payments made to you or your dependent by a third party or a third party's insurer, because of an injury or illness caused by a third party. Third party means another person or organization.

If you or your dependent receive Plan benefits and have a right to recover damages from a third party, the Plan is subrogated to this right. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse the Plan for benefits paid. Any remainder will be yours or your dependent's. The Plan's share of the recovery will not be reduced because you or your dependent has not received the full damages claimed, unless the Plan agrees in writing to a reduction.

You must promptly advise the Plan whenever a claim is made against a third party with respect to any loss for which Plan benefits have been or will be paid. You or your dependent must execute any assignments, liens or other documents and provide information as the Plan requests. Plan benefits may be withheld until documents or information is received. If you need more information about subrogation, the plan will provide you with its subrogation procedures.

Overpayments

The Carrier will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Vested rights

An enrollee does not have a vested right to receive the benefits in this brochure in 1999 or later years, and does not have a right to benefits available prior to 1998 unless those benefits are contained in this brochure.

General Limitations *continued*

Limit on your costs if you're age 65 or older and don't have Medicare

The information in the following paragraphs applies to you when 1) you are not covered by either **Medicare Part A** (hospital insurance) or **Part B** (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

If you are not covered by **Medicare Part A**, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b)) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called the equivalent Medicare amount. After the Plan pays, the law prohibits the hospital from charging you for covered services after you have paid any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge.

You and the Plan, together, are not legally obligated to pay the hospital more than the equivalent Medicare amount. The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or a refund, or are not sure how much you owe, call the plan at (301) 881-0510 or Member Services at (800) 605-8202 / (301) 294-3777.

Physician services

Claims for physician services provided for retired FEHB members age 65 and older who do not have **Medicare Part B** are also processed in accordance with 5 U.S.C. 8904 (b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the Medicare-approved amount (which is the Medicare fee schedule for the service), or actual charge, whichever is lower. If your doctor is a member of the Plan's preferred provider organization (PPO) and participates with Medicare, the Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and the PPO copayment or coinsurance.

If you go to a PPO doctor who does not participate with Medicare, you are responsible for any deductible and the copayment or coinsurance. In addition, unless the doctor's agreement with the Carrier specifies otherwise, you must pay the difference between the Medicare-approved amount and the limiting charge (115% of the Medicare-approved amount).

If your physician is not a Plan PPO doctor but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's high option surgery benefit, the Plan will pay 70% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 30% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance or copayment amount, and any balance up to the limiting charge amount (115% of the Medicare-approved amount).

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital or physician can charge you in addition to what the Plan paid. If you are billed more than the hospital or physician is allowed to charge, ask the hospital or physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the plan at (301) 881-0510 or Member Services at (800) 605-8202 / (301) 294-3777.

General Exclusions

These exclusions apply to more than one or to all benefits categories. Exclusions that are primarily identified with a single benefit category are listed along with that benefit category, but may apply to other categories. Therefore, please refer to the specific benefit sections as well to assure that you are aware of all benefit exclusions.

Benefits are provided only for services and supplies that are medically necessary (see definition). The Carrier reserves the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

Benefits will not be paid for services and supplies when:

- No charge would be made if the covered individual had no health insurance coverage
- Furnished without charge (except as described on page 8); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat
- Furnished by immediate relatives or household members, such as spouse, parents, children, brothers, or sisters by blood, marriage or adoption
- Furnished or billed by a provider or facility that has been barred from the FEHB Program
- Furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered
- For or related to sex transformation, sexual dysfunction or sexual inadequacy
- Not specifically listed as covered
- Investigational or experimental
- Not provided in accordance with accepted professional medical standards in the United States
- Not recommended and approved by a covered provider (as defined on page 6)
- Received before coverage under the Plan begins or ends

Benefits will not be paid for:

- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
- Charges the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 10), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge), or State premium taxes however applied.
- Any services rendered in relation to a learning disability
- Biofeedback therapy
- Chelation therapy, except for acute arsenic, gold, mercury, or lead poisoning
- Eye exercises and visual training (orthoptics)
- Hearing aids and examinations for them
- Milieu therapy
- Nutritional supplements and vitamins (except B12 injections for pernicious anemia)
- Services and supplies to the extent that the charge exceeds the reasonable and customary charge
- Weight control, or any treatment of obesity except surgery for morbid obesity
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is a result of an act of rape or incest

Benefits

Inpatient Hospital Benefits

What is covered	The Plan pays for inpatient hospital services as shown below.
Precertification	The medical necessity and the appropriateness of the setting of your hospital admission must be precertified for you to receive full Plan benefits. Emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by \$500. See page 34 for details.
Waiver	This precertification requirement does not apply to persons whose primary coverage is Medicare Part A or another health insurance policy or when the hospital admission is outside the United States and Puerto Rico. For information on when Medicare is primary, see pages 36 & 37.
Room and board	The Plan provides benefits for the following services: <ul style="list-style-type: none">• Semi-private room accommodations• Intensive care units• Private room when isolation is required to prevent contagion• Private room while semi-private rooms are unavailable• If the hospital has no semi-private rooms, 90% of its lowest private room rate• Meals, including special diets• General nursing services
Optimum Choice PPO benefit	The Plan pays 100% of covered hospital charges after a \$150 per admission deductible when admitted by your Plan provider to a network hospital. Admission must be coordinated by your primary care physician.
Non-PPO benefit	After a \$250 per admission deductible, the Plan pays 90% of covered hospital charges when billed as a regular inpatient hospital service.
Other charges	The Plan provides benefits for the following services: <ul style="list-style-type: none">• Ancillary services such as electrocardiograms and electroencephalograms• Intravenous solutions and injections• Oxygen, including use of equipment and administration• Use of operating, recovery, intensive care, and cystoscopic rooms• Laboratory tests• Surgical dressings, plaster casts, and sterile tray service• Diagnostic tests and X-rays• Drugs and medicines• Blood or blood plasma, if not donated or replaced, and its administration (only available under the non-PPO benefit)• Radiation therapy and inhalation therapy• Renal dialysis
Optimum Choice PPO benefit	The Plan pays 100% of covered hospital charges after a \$150 per admission deductible when admitted by your Plan provider to a network hospital. Admission must be coordinated by your primary care physician.
Non-PPO benefit	After a \$250 per admission deductible, the Plan pays 90% of covered hospital charges when billed as a regular inpatient hospital service.

Inpatient Hospital Benefits *continued*

Limited benefits

Pre-admission testing

Covered under Other Medical Benefits. See pages 21-23.

Hospitalization for dental work

The Plan pays hospital benefits for covered room and board and covered hospital services and supplies for hospitalization in connection with dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient.

Weekend admissions

When admission to a hospital takes place on Friday or Saturday, this Plan does not pay benefits for charges for services and supplies furnished on either of those days. This provision does not apply if surgery is performed within 24 hours of the admission or if the admission is for emergency care of an accidental injury or for a medical emergency as certified by a physician.

Related benefits

Pre-surgical testing

Covered under Other Medical Benefits. See pages 21-23.

Professional charges

Charges for professional services of a physician or any other practitioner covered by this Plan even though billed by a hospital on the practitioner's behalf are covered only under Other Medical Benefits (pages 21-23).

Take-home items

Drugs, medical supplies, appliances, medical equipment and any covered items billed by a hospital but to be used at home are covered only under Other Medical Benefits, see pages 21-23.

What is not covered

- A hospital admission that is not medically necessary, i.e., the medical services did not require the acute hospital inpatient (overnight) setting, but could have been provided in a physician's office, the outpatient department of a hospital, or some other setting without adversely affecting the patient's condition or the quality of medical care rendered.
- Charges by institutions that do not meet the definition of covered facilities (see pages 5 and 6).
- Confinement in nursing homes, rest homes, places for the aged, convalescent homes or any place that is not a hospital, skilled nursing facility or hospice (see pages 5 and 6).
- Custodial care (as defined on page 41) even when provided by a hospital.
- Inpatient private duty nursing.
- Personal comfort services of a luxury nature, such as radio, television, telephone, air conditioners, beauty and barber services, ID tags, baby beads, footprints, guest cots, guest meals, and newspapers.

~~The PPO, BPO, and HMO benefits are provided through the out-of-network benefits of this Physician PPO benefits. PPO benefits apply only when available.~~

Surgical Benefits

What is covered

The Plan pays for the following services:

- Surgery by a physician
- Breast reconstruction
- Charges for normal postoperative care by the doctor who performs surgery are considered to be part of the surgical charge

Hospital inpatient

Optimum Choice PPO benefit

The Plan pays 100% of covered charges for inpatient surgery, when care is coordinated by your Primary Care Physician.

Non-PPO benefit

After the \$250 calendar year deductible, the Plan pays 70% of reasonable and customary charges for inpatient surgery.

Outpatient

Optimum Choice PPO benefit

The Plan pays 100% of covered charges for outpatient surgery with no deductible, after a \$10 copayment for a primary care or specialty care physician.

Non-PPO benefit

After the \$250 calendar year deductible, the Plan pays 70% of reasonable and customary charges for outpatient surgery.

Multiple surgical procedures

When multiple or bilateral surgical procedures that add time or complexity to patient care are performed during the same operative session, the Plan pays as follows: the reasonable and customary fee is calculated allowing full value for the major procedure and 50% for a secondary procedure and 25% for all others. The determination of what constitutes multiple surgical procedures is made solely by the Plan.

Incidental procedures

When an incidental procedure is performed, the reasonable and customary fee is calculated based on the major procedure only. The determination of what constitutes incidental surgical procedure is made solely by the Plan.

Assistant surgeon (inpatient/outpatient)

Optimum Choice PPO benefit

- The Plan pays 100% of covered charges with no deductible for inpatient surgery.
- The Plan pays 100% of covered charges with no deductible for outpatient surgery, after a \$10 copayment for a specialty care physician.

Non-PPO benefit

After the \$250 calendar year deductible, the Plan pays 70% of reasonable and customary charges for inpatient or outpatient surgery.

Anesthesia

Optimum Choice PPO benefit

The Plan pays 100% of covered charges with no deductible, for a specialty care physician for inpatient or outpatient surgery.

Non-PPO benefit

After the \$250 calendar year deductible, the Plan pays 70% of reasonable and customary charges for the administration of general anesthesia for inpatient or outpatient surgery.

Surgical Benefits *continued*

Organ/tissue transplants and donor expenses

What is covered

All reasonable and customary charges incurred for a covered surgical transplant, whether incurred by the recipient or donor, will be considered expenses of the recipient and will be covered the same as for any other illness or injury when an Institutes of Excellence, PPO or Non-PPO facility is used. In order to receive benefits for the transplants listed below, you must follow the precertification procedures described on page 34. When you request precertification, a case management specialist will direct you to one of the Plan's PPO hospital in your area.

- Cornea, heart, kidney, liver, pancreas, heart/lung, single lung and double lung transplants
- Bone marrow and stem cell support as follows:
Allogeneic bone marrow transplants limited to patients with (1) Acute leukemia, (2) Advanced Hodgkins lymphoma, (3) Advanced non-Hodgkin's lymphoma, (4) Advanced neuroblastoma (limited to children over age one), (5) Aplastic anemia, (6) Chronic myelogenous leukemia, (7) Infantile malignant osteoporosis, (8) Severe combined immunodeficiency, (9) Thalassemia major, or (10) Wiskott-Aldrich syndrome.

Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support with associated high dose chemotherapy, limited to patients with (1) Acute lymphocytic, or non-lymphocytic leukemia, (2) Advanced Hodgkin's lymphoma, (3) Advanced non-Hodgkin's lymphoma, (4) Advanced neuroblastoma, (5) Testicular, Mediastinal, Retroperitoneal and Ovarian germ cell tumors, (6) multiple myeloma, (7) Breast cancer, or (8) epithelial ovarian cancer.

Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan. Recipient means an insured person who undergoes an operation to receive an organ transplant. Donor means a person who undergoes an operation for the purpose of donating an organ for transplant surgery.

Optimum Choice PPO benefit

The Plan pays 100% of covered charges for the above transplants when coordinated by your primary care physician.

Non-PPO benefit

The Plan pays 70% of reasonable and customary charges after the calendar year deductible has been met when the transplant is performed at a PPO hospital. If the transplant is performed at a non-PPO hospital, then the Plan pays 70% of reasonable and customary charges after the plan deductible up to a maximum, per transplant, of \$150,000 for a liver transplant and \$100,000 for any of the other listed transplants.

Limitations

- Precertification of the procedure and the facility is required for all transplants (see page 34).
- \$150,000 benefit maximum for a liver and a \$100,000 benefit maximum for other covered transplants when not performed in a PPO hospital. For the purposes of this limitation, charges from the doctor and hospitals while the patient is confined in a transplant facility will be counted toward the maximum. Charges incurred for prescription drugs and follow-up care outside of the transplant facility/hospital will not be counted toward this maximum. If the Plan cannot refer a member in need of a transplant to a PPO hospital, the \$100,000/\$150,000 maximum will not apply.

What is not covered

- Transplants not listed as covered.
- Travel expenses related to transplant benefit.

Surgical Benefits *continued*

Mastectomy surgery

Women who undergo mastectomies may, at their option have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.

Oral and maxillofacial surgery

Optimum Choice PPO benefit

- The Plan pays 100% of covered charges for oral and maxillofacial surgery for inpatient surgery when referred by your primary care physician.
- The Plan pays 100% of covered charges for oral and maxillofacial surgery with no deductible for outpatient surgery, after a \$10 copayment for a primary care or specialty care physician.
- There is no coverage for temporomandibular joint (TMJ) treatment under the Optimum Choice PPO benefit.

Non-PPO benefit

After the \$250 calendar year deductible, the Plan pays 70% of reasonable and customary charges for inpatient or outpatient surgery by a dental surgeon for operations performed on the jaw for nondental oral surgery in the mouth, including surgical correction of TMJ dysfunction.

Reconstructive surgery

Reconstructive surgery will be covered (see Definitions on page 43).

Pre-surgical testing

Covered under Other Medical Benefits. See Page 21-23.

What is not covered

- Cosmetic surgery (as defined on page 41)
- Dental appliances, study models, splints and other devices or services associated with the treatment of TMJ dysfunction
- Dental surgery except as specifically provided under Dental benefits
- Impacted wisdom teeth and osseous surgery
- Radial keratotomy
- Reversal of sterilization
- Services or supplies for or related to surgical transplants including artificial or human organ transplants other than those specifically listed as covered
- Treatment or removal of corns and calluses, or trimming of toenails

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when care is provided by or coordinated through your Primary Care Physician. When no PPO provider is available, non-PPO benefits apply.

Maternity Benefits

What is covered

The Plan pays the same benefits for hospital, surgery (delivery), laboratory tests and other medical expenses as for illness or injury. The mother may, at her option, remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary, and must be precertified.

Inpatient hospital

Bassinet or nursery charges for days on which mother and child are both confined are considered hospital expenses of the mother. All other expenses of the newborn child are covered only if the child's confinement is for treatment of illness or injury and then only if the child is covered by a Self and Family enrollment.

Precertification

The medical necessity and the appropriateness of the setting of your hospital admission must be precertified for you to receive full Plan benefits. Unscheduled or emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Newborn confinements that extend beyond the mother's discharge must also be precertified. If any of the above are not done, the benefits payable will be reduced by \$500. See page 34 for details.

Room and board

The Plan provides benefits for the following services:

- Semi-private room accommodations
- Intensive care units
- Private room when isolation is required to prevent contagion
- Private room while semi-private rooms are unavailable
- If the hospital has no semi-private rooms, 90% of its lowest private room rate
- Meals, including special diets
- General nursing services

Optimum Choice PPO benefit

The Plan pays 100% of covered inpatient hospital charges after a \$150 per admission deductible when care is coordinated through your primary care physician.

Non-PPO benefit

After the \$250 per admission deductible, the Plan pays 90% for covered inpatient hospital charges.

Other charges

Optimum Choice PPO benefit

The Plan pays 100% of covered inpatient hospital charges after a \$150 per admission deductible when care is coordinated through your primary care physician.

Non-PPO benefit

After a \$250 per admission deductible, the Plan pays 90% of covered hospital inpatient charges for services when billed as a regular inpatient hospital service.

Outpatient care

Optimum Choice PPO benefit

The Plan pays 100% of covered charges at an approved birthing center after a \$10 copayment.

Non-PPO benefit

After the \$250 per admission deductible, the Plan pays 70% of reasonable and customary charges

- Delivery is on an outpatient basis; and
- Delivery is at a birthing center.

If the mother or newborn child is transferred from a birthing center to a hospital due to medical complications, the birthing center expenses will be paid as shown above.

Maternity Benefits *continued*

Obstetrical care

Optimum Choice PPO benefit

- The Plan pays 100% of covered inpatient hospital charges when care is coordinated through your primary care physician.
- The Plan pays 100% of covered charges with no deductible each pregnancy after a \$10 copayment for physician and midwife care. Nurse midwife must be associated with an approved center.

Non-PPO benefit

After the \$250 calendar year deductible, the Plan pays 70% of reasonable and customary charges for covered expenses due to delivery. Physicians' fees for total obstetrical care cannot be considered until time of delivery. Routine circumcision of the newborn child is payable under Surgical Benefits as part of the mother's claims.

Related benefits

Contraceptive drugs and devices

Contraceptive drugs are covered through the Prescription Drug Program. See page 26.

Diagnosis and treatment of infertility

Initial diagnostic tests and procedures done solely to identify the cause or causes for the inability to conceive are covered under Other Medical Benefits, page 21. Physician's services for the treatment of infertility are covered at 70% after the calendar year deductible, limited to \$1,000 per person per calendar year. Prescription drugs used for the treatment of infertility are covered under the Prescription Card and Mail Order Programs, limited to \$1,000 per person per calendar year.

Voluntary sterilization

See Surgical Benefits, pages 14-16.

For whom

Benefits are payable under Self Only enrollments and for family members under Self and Family enrollments.

What is not covered

- Assisted Reproductive Technology (ART) procedures such as artificial insemination, in vitro fertilization, embryo transfer and GIFT, as well as services and supplies related to ART procedures are not covered.
- Contraceptive devices
- Implanted time-release medications such as Norplant
- Reversal of sterilization
- Abortions, unless the life of the mother is in danger.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when care is provided by or coordinated through your Primary Care Physician. When no PPO provider is available, non-PPO benefits apply.

Mental Conditions / Substance Abuse Benefits

What is covered

The Plan pays for the following services:

Mental conditions

Inpatient facility care

Optimum Choice PPO benefit

After a \$50 copayment per day, the Plan pays 100% of covered charges up to 35 days. Your maximum copayment is \$300 per year. Coverage is in combination with the benefits for physician visits as stated below.

Non-PPO benefit

After you pay the first \$500 of covered hospital charges per person each calendar year, the Plan will pay 80% of covered charges up to 100 days per person per calendar year.

Precertification

The medical necessity and the appropriateness of the setting of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by \$500. See page 34 for details.

Inpatient physician visits

Optimum Choice PPO benefit

After a \$50 copayment per day, the Plan pays 100% of covered charges up to 35 days. Your maximum copayment is \$300 per year. Coverage is in combination with benefits for Inpatient Care as stated above.

Non-PPO benefit

The Plan pays 50% of covered charges for physicians' inpatient or outpatient visits for the treatment of mental conditions or substance abuse limited to 20 visits per person each calendar year after the \$250 calendar year deductible has been met. These services are covered only when rendered by a licensed M.D., a licensed clinical psychologist, a licensed psychiatric social worker, or a licensed psychiatric nurse.

Outpatient physician visits

Optimum Choice PPO benefit

75% of covered charges up to 40 visits per year when referred by your primary care physician.

Non-PPO benefit

The Plan pays 50% of covered charges for physicians' inpatient or outpatient visits for the treatment of mental conditions or substance abuse limited to 20 visits per person each calendar year after the \$250 calendar year deductible has been met. These services are covered only when rendered by a licensed M.D., a licensed clinical psychologist, a licensed psychiatric social worker, or a licensed psychiatric nurse.

Substance abuse

Inpatient care

Optimum Choice PPO benefit

Coverage is in combination with benefits for mental conditions (see inpatient care under mental conditions).

Non-PPO benefit

Benefits for substance abuse are limited to \$5,500 for one 30-day inpatient program per person per calendar year in a JCAH approved facility. Withdrawal prior to completion constitutes use of one program. Benefits for inpatient detoxification are limited to 7 days per admission.

Inpatient physician visits

Coverage is in combination with benefits for mental conditions (see Inpatient physician visits under Mental Conditions).

Mental Conditions / Substance Abuse Benefits *continued*

Outpatient physicians visits

Optimum Choice PPO benefit

70% of covered charges up to 40 visits per year when referred by your primary care physician. Coverage is in combination with benefits for outpatient care of mental conditions.

Non-PPO benefit

The Plan pays 50% of covered charges for physicians' visits for the treatment of mental conditions or substance abuse limited to 20 visits per person each calendar year after the calendar year deductible has been met.

Lifetime maximum

The benefits for substance abuse are limited to two programs per person per lifetime.

Day treatment

The Plan pays for inpatient days being exchanged for outpatient day treatments at a rate of two day treatments for each inpatient day for mental health and substance abuse, subject to the mental condition/substance abuse deductible and coinsurance.

What is not covered

- Marital, family and other counseling services including therapy for sexual problems
- Psychoanalysis of psychiatrists, psychologists, and others who are psychoanalytic candidates in training, regardless of whether or not they have a diagnosed mental disorder
- Services rendered or billed by a school or halfway house or a member of its staff

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when care is provided by or coordinated through your Primary Care Physician. When no PPO provider is available, non-PPO benefits apply.

Other Medical Benefits

What is covered

- Allergy treatment including injections and testing
- Blood or blood plasma (that is not donated or replaced) and its administration for which inpatient hospital benefits are not available or as a result of inpatient surgery
- Casts, splints, crutches, canes, cervical collars, traction kits, and trusses
- Chemotherapy
- Diabetic supplies (excluding insulin)
- Diagnostic procedures, including laboratory work, X-rays, and tests such as electrocardiograms, basal metabolism readings, and electroencephalograms
- Home IV therapy
- Injectable B-12 for a diagnosis of pernicious anemia
- Inpatient anesthesia services
- Local professional ambulance service. If special hospital treatment requiring special equipment is necessary but not available locally, the Plan also covers transportation within the United States or Canada by professional ambulance, railroad or scheduled commercial airlines to the hospital equipped to furnish the treatment, nearest the medical emergency. This benefit does not apply to transportation necessary to obtain the services of a physician or any other practitioner
- Non-emergency treatment at a hospital
- Oxygen and rental of equipment for its administration
- Physicians' services including office, home, and hospital visits
- Radium, radioactive isotopes, and X-ray therapy
- Renal dialysis treatment
- Services by an independent consulting physician for a second opinion regarding the necessity for anticipated surgery
- Services of a registered physical therapist or administration of physical therapy in accordance with a physician's specific instructions as to type, frequency, and duration
- Speech therapy limited to charges of a qualified speech therapist for speech loss or impairment due to a congenital anomaly defect whether or not surgically corrected or due to any other illness or surgery

Optimum Choice PPO benefit

The Plan pays 100% of covered charges with no deductible, after a \$10 copayment for a primary care or specialty care physician. Specific exclusions under the Optimum Choice PPO include: blood or blood products; eye glasses or contact lenses pertaining to an accident; orthotics; private duty nurses; and transportation within the United States or Canada by professional ambulance, railroad or scheduled commercial airlines to the hospital equipped to furnish the treatment, nearest the medical emergency.

Non-PPO benefit Precertification

After the \$250 calendar year deductible, the Plan pays 70% of reasonable and customary charges.

The following list of outpatient procedures must be precertified by Optimum Choice, Inc., Utilization Management for appropriateness of setting and authorization. This step will help to determine the medical necessity for a treatment before the procedure is performed. The member, the member's attending physician, or any other person acting on the members behalf may contact Utilization Management at (800) 555-6600 or (301) 251-4082.

- angiomas/hemangioma treatment
- blepharoplasty
- breast implant removal
- breast reconstruction
- cataract surgery
- chiropractic treatment
- cholecystectomy by laparoscopy
- cochlear implants
- congenital anomaly repair
- dialysis
- growth hormone treatment
- gynecomastia surgery
- hyperbaric treatment
- infertility services
- neurological - psychological / psychological testing
- non-functional abnormality correction
- outpatient psychiatric therapies, including psychiatric day treatment, psychiatric shock treatment, and substance abuse treatment
- pelvic laparoscopy
- physical therapy
- radiation therapy
- reduction mammoplasty
- rhinoplasty
- sclerotherapy
- speech therapy
- TMJ pain treatment
- uvulopalatopharyngoplasty (UPPP)

Other Medical Benefits *continued*

Routine Services

In addition to coverage of diagnostic X-rays, laboratory and pathology services and machine diagnostic tests, the following routine (screening) services are covered as preventive care.

Breast cancer screening

Mammograms are covered for women age 35 and older as follows:

- From age 35 through 39, one mammogram screening during this five year period
- From age 40 through 49, one mammogram screening every one or two consecutive calendar years
- From age 50 through 64, one mammogram screening every calendar year
- At age 65 and older, one mammogram screening every two consecutive calendar years

Cervical cancer screening

Annual coverage of one pap smear for women age 18 and older

Colorectal cancer screening

Annual coverage of one fecal occult blood test for members age 40 and older

Prostate cancer screening

Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older

Optimum Choice PPO benefit

The Plan pays 100% of covered charges with no deductible after a \$10 copayment when services are provided by or coordinated through your Primary Care Physician.

Non-PPO benefit

After the \$250 calendar year deductible, the Plan pays 70% of reasonable and customary charges.

Routine physical

Optimum Choice PPO benefit

The Plan pays 100% of covered charges with no deductible for routine services, after a \$10 copayment. Services must be provided by your Primary Care Physician. Also, after a \$10 copayment, 100% of covered charges with no deductible is provided for gynecological examinations, pap smears, and mammographies.

Non-PPO benefit

After the \$250 calendar year deductible, the Plan pays 70% of reasonable and customary charges up to \$150 per person per calendar year for routine physical examinations and tests and adult immunizations. The 30% out-of-pocket expenses will be applied toward the catastrophic protection provision.

Other Optimum Choice PPO benefits

- Allergy sera is covered under the Optimum Choice PPO as part of the \$10 specialist copayment when referred by your Primary Care Physician.
- The Plan will pay 100% of covered charges after a \$10 copayment (up to 60 days per condition) when referred to a participating acupuncture therapist by your Primary Care Physician.

Durable medical equipment

Optimum Choice PPO benefit

50% of covered charges. If the durable medical equipment eliminates a hospital admission, then covered at 100%. Orthotics are not covered under this benefit.

Non-PPO benefit

After a \$250 calendar year deductible, the Plan pays 70% of reasonable and customary charges for the following:

- Orthopedic braces and prosthetic devices (orthotics), when ordered by a physician, including replacement when required by a change in the patient's physical condition.
- Rental (or purchase at the option of the Plan) of a hospital-type bed, wheelchair, certain types of traction equipment, or durable medical equipment as defined on page 41.

Limited benefits

Accidental dental injury

Dentists' services (including initial replacement, repair and dental X-rays) necessary due to accidental injury to the jaw or sound natural teeth. The accident must occur, and the expenses must be incurred while insured under the Plan. Services must be received within 12 months of the accident.

Lenses following eye injury or surgery

One pair of eyeglasses or contact lenses, and examinations therefor, if required to correct an impairment directly caused by accidental ocular injury or intraocular surgery.

Private duty nursing

Private duty professional nursing care outside a hospital by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) or a licensed vocational nurse (L.V.N.), limited to not more than 240 hours per patient in a calendar year

Other Medical Benefits *continued*

Limited benefits (con't)

**Optimum Choice
PPO benefit**

There are no PPO benefits for accidental dental injury, lenses following eye injury or surgery or private duty nursing.

**Non-PPO
benefit**

After the \$250 calendar year deductible, the Plan pays 70% of reasonable and customary charges for accidental dental injury, lenses following eye injury or surgery or private duty nursing.

Chiropractor

**Optimum Choice
PPO benefits**

The Plan pays 100% of covered charges after a \$10 copayment (up to 60 days per condition) when referred to a participating chiropractor by your primary care physician.

Non-PPO benefits

After the \$250 calendar year deductible, the Plan pays 70% of reasonable and customary charges for services of a chiropractor practicing within the scope of his or her license, limited to \$300 per person per calendar year.

Smoking cessation benefit

**Optimum Choice
PPO benefit**

There is no PPO benefit.

**Non-PPO
benefit**

After satisfaction of the \$250 calendar year deductible, the Plan will pay up to \$100 for enrollment program per member per lifetime.

Cardiac rehabilitation program

A cardiac rehabilitation program consists of outpatient cardiac rehabilitative exercise, education, and counseling. Patients must be diagnosed as having angina pectoris (chest pain) or must have been hospitalized for a diagnosed myocardial infarction (heart attack) or coronary surgery to be eligible for cardiac rehabilitative benefits. To be covered, services must be provided by an outpatient visits during the course of a cardiac rehabilitative treatment plan. Cardiac rehabilitation benefits are renewed by further hospital admissions for diagnosed myocardial infarctions or coronary surgeries.

**Optimum Choice
PPO benefit**

The Plan pays 100% of covered charges with no deductible after a \$10 copayment.

**Non-PPO
benefit**

After the \$250 calendar year deductible, the Plan pays 70% of reasonable and customary charges for up to 90 outpatient visits during the course of a cardiac rehabilitative treatment plan.

Pre-surgical testing

When a covered surgical procedure is performed in an outpatient or inpatient setting, the Plan pays the allowable charges for laboratory tests, pathology, radiology and X-rays directly related to the surgery when performed within 10 days prior to the surgery (including the day of the surgery) when an outpatient, or within 10 days prior to admission for inpatient surgery.

**Optimum Choice
PPO benefit**

The Plan pays 100% of covered charges with no deductible after a \$10 copayment when care is coordinated through your primary care physician.

**Non-PPO
benefit**

After the \$250 calendar year deductible, the Plan pays 70% of reasonable and customary charges.

What is not covered

- Eyeglasses, contact lenses or examination for them except as provided above
- Preventive medical care and services except as provided under the routine physical benefit, and well child care benefit, see page 25
- Provocative food testing and end-titration techniques and sublingual allergy desensitization
- Routine mammography screening for enrollees under age 35 except as provided under the routine physical benefit
- Sun or heat lamps, whirlpool baths, heating pads, air purifiers, humidifiers and exercise devices

The PPO benefit is only available for Optimum Choice PPO. PPO benefits apply only where available,

Additional Benefits *continued*

Skilled nursing facilities

Skilled nursing facility benefits are payable under this Plan when:
(1) The member is confined in a skilled nursing facility for a period of at least 3 consecutive days beginning

Optimum Choice PPO benefits

The Plan pays 100% of covered charges for skilled nursing care for up to 60 days.

Non-PPO benefits

If a person is confined in a skilled nursing facility (as defined on page 5), the Plan will, for a maximum of 60 days, pay up to 90% of the average semi-private room rate of the skilled nursing facility. The 10% out-of-pocket expense cannot be applied toward the catastrophic protection provision.

Well child care

Optimum Choice PPO benefit

The Plan pays 100% of covered charges with no deductible for well child care, after a \$10 copayment for a primary care physician. Services must be provided by your primary care physician. Childhood immunizations are covered.

Non-PPO benefit

After the \$250 plan deductible, the plan pays 70% of reasonable and customary charges for well child examinations during the 12 months following birth.

Immunizations

Childhood immunizations recommended by the American Academy of Pediatrics are covered for eligible members under age 22 at 100% of reasonable and customary charges and are not subject to the calendar year deductible. Associated office visits charges are covered under Other Medical Benefits, see pages 21-23.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when care is provided by or coordinated through your Primary Care Physician. When no PPO provider is available, non-PPO benefits apply.

Prescription Drug Benefits

What is covered

You may purchase the following medications and supplies prescribed by a doctor from either a pharmacy or by mail:

- Drugs, including those for smoking cessation, that by Federal law of the United States require a doctor's prescription for their purchase
- Insulin
- Needles and syringes for the administration of covered medications
- Drugs for the treatment of infertility are limited to \$1,000 per person per calendar year
- Contraceptive drugs

What is not covered

- Medical supplies such as dressings and antiseptics
- Drugs and supplies for cosmetic purposes
- Medication that does not require a prescription under Federal law even if your doctor prescribes it or a prescription is required under your State law
- Contraceptive devices for which Federal law requires a prescription
- Nutritional supplements and vitamins (except B12 injections for pernicious anemia)
- Implanted time-release medications such as Norplant

The copayments, and any amounts you are required to pay when you purchase a name brand drug when a generic equivalent is available, are not eligible for reimbursement by the Plan and do not count toward the catastrophic protection benefit.

Precertification

The following classifications of drugs need to be preauthorized by calling Optimum Choice, Inc. at (800) 555-6600 or (301) 251-4028:

- Myeloid Stimulants (brand name: Neupogen; generic name: Filgrastim)
- Mrythoid Stimulants (brand name: Procrit; generic name: Epoetin Alfa)
- Interferons (brand names: Intron A, Alferon N, Betaseron, and Actimmune; generic names: interferon alfa-2b, interferon alfa-n3, interon beta-1b, and interferon gamma-1b)
- Growth Hormones (brand names: Protropin, Nutropin; generic names: somaterm, Somatropin)
- Interleukins (brand name: Proleukin; generic name: aldesleukin (interleukin-2))
- Anti-infective Drugs (brand name: Mepron; generic name: Atovaquone)
- Oral Antifungal Drugs (Brand names: Diflucan, Sporanox and Lamisil; generic names: Fluconazole, itraconazole and terbinafine)
- Drugs for the treatment of infertility (brand names: Pergonal and Metrodin; generic names: menotropins and urofollitropin)
- CNS Stimulants and CNS/Autonomic Drugs (brand name: Cognex; generic name: tacrine)

From a pharmacy

You may purchase up to a 30-day supply of covered drugs or supplies through a participating pharmacy. Call 1-800-605-8202 or (301) 294-3777 to locate a Plan network pharmacy in your area.

You should use your medical identification card to obtain prescription drugs. In most cases, you simply present the card, together with the prescription, to the pharmacist. After a \$50 prescription deductible per covered family member, a \$10 copayment is required for each prescription. If you request, but your physician does not require, a name brand drug and a generic equivalent is available, you will also be required to pay the difference in cost between the name brand drug and the generic substitute (in both the prescription card and mail order program).

Be sure to present your card with each prescription. The pharmacist receives an electronic message displaying the correct amount to charge you. You will be required to sign a signature log to prove you have received the prescription drug. The system files the claim for you.

If your physician prescribes a medication that will be taken over an extended period of time, you should request two prescriptions - one to be used for the local participating pharmacy and the other for the Mail Order Drug Program. You may only obtain up to a 30-day supply, with one refill, per prescription through the prescription card program.

Prescription Drug Benefits *continued*

To claim benefits

To claim benefits for prescription drugs and supplies you purchased without your identification card, mail the receipt from the pharmacy with the pharmacy's name, address and telephone number, the prescription number, the drug's name, strength and quantity to:

The BACE Health Plan
160 N. 5th St., 11th Floor
Columbia, MD 21045

Your claim will be subject to the \$10 copayment. Reimbursement will be limited to BACE's cost had you used a participating pharmacy.

By mail

If your doctor orders more than a 30 day supply of drugs or covered supplies, up to a 90-day supply, you may order your prescription or refill by mail from the Mail Order Drug Program. Home Call Mail RX will fill your prescription. All drugs and supplies listed above are covered under this Program.

Under the Mail Order Drug Program, if a generic equivalent to the prescribed drug is available, the pharmacy will dispense the generic equivalent instead of the name brand unless your doctor specifies that the name brand is required. You pay a \$10 copayment for each prescription drug, supply, or refill you purchase through the Mail Order Drug Program.

Waiver

When Medicare Part B is the primary payer, and you use the Mail Order Drug Program, your copayment is waived after you supply proof of your enrollment in Part B directly to HomeCall Mail RX.

To claim benefits

The Plan will send you information on the Mail Order Drug Program. To use the Program:

- (1) Call HomeCall Mail RX to get a prescription for your order 90-day supply of your regular drugs or supplies.
- (2) Mail the prescription to:
HomeCall Mail RX
P.O. Box 2877
Columbia, MD 21045

(5) Allow approximately two weeks for delivery.

If necessary, you will receive a bill from HomeCall Mail RX together with your filled prescription. This will be included with the delivery of your filled prescription.

You must pay your share of the cost by check or money order. There is a space on your order envelope so that you may charge your part of the cost to a VISA or MasterCard credit card.

You'll receive forms for refills and future prescription orders each time you receive drugs or supplies under this Program. In the meantime, if you have any questions about a particular drug or a prescription, and to request your first order forms, you may call toll-free: 1-800/385-9090.

Drugs from other sources

Prescription drugs are also covered under this Plan when they are provided to you by a doctor or facility. Pay the provider directly, obtain an itemized bill and mail to the claims office as directed above, "To claim benefits."

Coordinating with other drug coverage

If you have drug coverage through another carrier, and BACE is secondary, do not present your prescription drug card. Purchase your drug and submit the bill to your primary carrier. When they have made payment, file the claim and Explanation of Benefits (EOB) with BACE's claims office (see page 30). If you use BACE's prescription drug card when another carrier is primary, you may be responsible for reimbursing BACE any amount in excess of BACE's secondary benefit.

**Purchasing drugs
when you are
overseas**

Pay the provider directly, obtain an itemized bill and mail to the claims office as directed above, "To claim benefits."

Dental Benefits

What is covered

Preventive care

Where the following schedule of dental allowances provides for a category of service, but does not specifically list a particular procedure belonging to that category, the Plan will determine the maximum allowance for that procedure.

The Plan pays 100% of reasonable and customary charges up to the amounts specified in the schedule of dental allowances with no deductible.

Schedule of dental allowances

Oral Exam	\$ 11
Complete X-Ray Series	31
Panoramic X-Ray	31
Single Film X-Ray	5
Each Additional X-Ray Film (up to 7)	3
Bitewings 2 Films	9
Bitewings 4 Films	13
Prophylaxis Adult	20
Prophylaxis Child (through age 14)	14
With Fluoride Treatment	22
Space Maintainer	78

Restorative care

After a deductible of \$25 per person per calendar year, the Plan pays 100% of reasonable and customary charges up to the amounts specified in the schedule of dental allowances.

Schedule of dental allowances

Restorations

Amalgam - 1 Surface Deciduous	\$ 12
Amalgam - 2 Surfaces Deciduous ..	16
Amalgam - 3 or more Surfaces Deciduous.....	21
Amalgam - 1 Surface Permanent	12
Amalgam - 2 Surfaces Permanent.....	18
Amalgam - 3 or more Surfaces Permanent	23
Silicate Cement 1	12
Acrylic or Plastic	19

Extractions (uncomplicated)

Single Tooth	14
Each Additional Tooth	13

Extractions of impacted teeth

Erupted	24
Soft Tissue	36
Partial Bony	53
Complete Bony	65
Pulp Capping - Direct	9
Pulpotomy - Vital	15

Root canal therapy

One Root	93
Two Roots	113
Three or more Roots	149
Gingival Curettage (per quadrant)	25
Gingivectomy (per quadrant)	66

Crowns

Plastic with Gold	105
Porcelain	100
Gold (Full Cast)	105
Gold (3/4 Cast)	105
Stainless Steel	19

Dental Benefits *continued*

Restorative care continued

Dentures

Complete Upper or Lower	113
Partial without Bar	123
Partial with Bar	141
Relining _ Lab	35
Pontic Porcelain Fused to Gold	105
Dowel Pin	27
General anesthesia (office)	33

Dental benefit deductible

The \$25 deductible applies only to restorative care dental benefits. It is applied only once in a calendar year for each person. You may count toward the deductible only those expenses covered under the restorative care schedule of dental allowances. You cannot count toward the deductible any charges in excess of the amounts listed in the schedule of dental allowances.

Related benefits Oral and maxillofacial surgery

For covered oral surgery, see page 16.

What is not covered

- Any service covered under another provision of the Plan
- Charges related to orthodontia
- Non-surgical treatment of temporomandibular joint (TMJ) dysfunction including dental appliances, study models, splints and other devices

How to Claim Benefits

Claim forms and identification cards

If you do not receive your identification card(s) within 60 days after the effective date of your enrollment, call the Carrier at 301/881-0510 to report the delay. In the meantime, use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services. This is also the number to call for claim forms or advice on filing claims.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with providers.

How to file claims

Claims filed by your doctor that include an assignment of benefits to the doctor are to be filed on the form HCFA-1500, Health Insurance Claim Form. Claims submitted by enrollees may be submitted on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

In addition:

- A copy of the explanation of benefits (EOB) from any primary payer (such as Medicare) must be sent with your claim.
- Bills for psychotherapy must show the length and type of each session.
- Bills for private duty nurses must show that the nurse is a registered or licensed practical nurse and must include nursing notes.
- Claims for prescription drugs and medicines that are not ordered through the mail order drug program must include receipts that include the prescription number, name of the drug, the prescribing doctor's name, date and charge.
- Claims for rental or purchase of durable medical equipment, private duty nursing, and physical, occupational and speech therapy require a written statement from the doctor specifying the medical necessity for the service or supply and the length of time needed.
- Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred. If possible, include a receipt showing the exchange rate on the date the claimed services were performed.

Canceled checks, cash register receipts or balance due statements are not acceptable.

After completing a claim form and attaching proper documentation, send claims to:

BACE Health Benefit Plan
1600 S. 17th St., 2050 Health

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. The Carrier will not provide duplicate or year end statements.

Submit claims promptly

You are strongly encouraged to file your claims within 12 months of the date the service was rendered. All claims must be received by the Plan no later than 24 months after the date of service. Claims for Other Medical Benefits preferably should not be submitted more than once per month. The Carrier will not pay benefits for claim submitted more than two years after the date the charge was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. If the Plan returns a claim or part of a claim for additional information, it must be resubmitted within 90 days, or within 24 months of the date of service, whichever is later.

How to Claim Benefits *continued*

Direct payment to hospital or provider of care

If you wish to authorize direct payment to a hospital, show your identification card upon admission. The hospital will furnish their own form or will send an itemized statement to the BACE Health Plan.

Submit hospital and doctor bills to show:

- Name of the person for whom the service was rendered
- Name of the attending physician and/or admitting hospital and address
- Date charge was incurred, statement of the diagnosis, treatment rendered and amount of the charge for each service

When more information is needed

Reply promptly when the Carrier requests information in connection with a claim. If you do not respond, the Carrier may delay processing or limit the benefits available.

Confidentiality

Medical and other information provided to the Carrier, including claim files, is kept confidential and will be used only: 1) by the Carrier and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

Reconsideration

If a claim for payment is denied by the Carrier, you must ask the Carrier, in writing and within six months of the date of the denial, to reconsider its decision before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Carrier an opportunity to reconsider your claim. Before you ask the Carrier to reconsider, you should first check with your provider or facility to be sure that the claim was filed correctly. For instance, did they use the correct procedure code for the service(s) performed (surgery, laboratory test, X-ray, office visit, etc.)? Indicate any complications of any surgical procedure(s) performed. Include copies of an operative or procedure report, or other documentation that supports your claim. Your written request to the Carrier must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment should have been paid.

Within 30 days after receipt of your request for reconsideration, the Carrier must affirm the denial in writing to you, pay the claim, or request additional information that is reasonably necessary to make a determination. If the Carrier asks a provider for information it will send you a copy of this request at the same time. The Carrier has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Carrier will base its decision on the information it has on hand.

How to Claim Benefits *continued*

OPM review

If the Carrier affirms its denial, you have the right to request a review by OPM to determine whether the Carrier's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Carrier's letter affirming its initial denial.

~~THE FOLLOWING INFORMATION IS FOR YOUR INFORMATION ONLY. IT IS NOT A CONTRACT. IT IS SUBJECT TO CHANGE WITHOUT NOTICE.~~

- A copy of your letter to the Carrier requesting reconsideration;
- A copy of the Carrier's reconsideration decision (if the Carrier failed to respond, provide instead a) the date of your request to the Carrier, or (b) the dates the Carrier requested and you provided additional information to the Carrier);
- Copies of documents that support your claim (such as doctors' letters, operative reports, bills, medical records, explanation of benefit (EOB) forms); and
- Your daytime phone number.

~~THE FOLLOWING INFORMATION IS FOR YOUR INFORMATION ONLY. IT IS NOT A CONTRACT. IT IS SUBJECT TO CHANGE WITHOUT NOTICE.~~

Privacy Act statement: If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Carrier to determine if the Carrier has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Carrier in support of OPM's decision on the disputed claim.

Protection Against Catastrophic Costs

Catastrophic protection

For those services with coinsurance, the Plan pays 100% of reasonable and customary charges for the remainder of the calendar year after the calendar year deductible is met when out-of-pocket expenses for coinsurance in that calendar year exceed \$3,000 for Self Only enrollment or \$3,000 for Self and Family enrollment.

Out-of-pocket expenses for the purposes of this benefit are:

- The \$250 inpatient hospital admission deductible under the Non-PPO;
- The 30% you pay for inpatient and outpatient surgery;
- The 30% you pay for physician and midwife care under Maternity Benefits;
- The 30% you pay for Other Medical Benefits and routine physicals under Additional Benefits;
- The 10% you pay for inpatient hospitalization; and
- The 30% you pay for covered well child care.

The following cannot be counted toward out-of-pocket expenses:

- Expenses in excess of reasonable and customary charges or maximum benefit limitations;
- Copayments required under the Optimum Choice PPO;
- \$150 per admission deductible under the Optimum Choice PPO;
- Expenses for mental conditions, substance abuse or dental care;
- Expenses for skilled nursing facility confinements;
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 12, 14,17,19, 21, 26 and 34);
- The calendar year deductible of \$250 for Self Only enrollment or \$500 for Self and Family enrollment; and
- The prescription drug deductible of \$50 per covered family member.

Mental conditions / Substance abuse benefits

The Plan pays 100% of reasonable and customary charges for the remainder of the calendar year up to the annual maximum of \$50,000 after the \$500 deductible is met, if out-of-pocket expenses for inpatient mental conditions/substance abuse treatment total \$8,000 for the covered person in that calendar year.

Carryover

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

Other Information

Precertification

Precertify before admission

Precertification is not a guarantee of benefit payments. Precertification of an inpatient admission is a predetermination that, based on the information given, the admission meets the medical necessity and the appropriateness of the setting requirements of the Plan. It is your responsibility to ensure that precertification is obtained. If precertification is not obtained and benefits are otherwise payable, benefits for the admission will be reduced by \$500.

To precertify a scheduled admission:

- You, your representative, your doctor, or your hospital must call Optimum Choice, Inc., prior to admission. The toll-free number is 1-800/555-6600 or 301-251-4082.
- Provide the following information: enrollee's name and Plan identification number; patient's name, birth date and phone number; reason for hospitalization, proposed treatment or surgery; name of hospital or facility; name and phone number of admitting doctor; and number of planned days of confinement.

Optimum Choice, Inc will then tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition. Written confirmation of the Carrier's precertification decision will be sent to you upon request. If it is determined that the length of stay needs to be extended, follow the procedures listed below. If the admission is precertified but you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for charges incurred on any extra days that are determined by the Plan during the claim review to be medically necessary.

Need additional days?

A review coordinator will contact your doctor before the certified length of stay ends to determine if you will be discharged on time or if additional days are medically necessary. If the admission is precertified but you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for charges incurred on any extra days that are determined to not be medically necessary by the Carrier during the claim review.

You don't need to certify an admission when:

- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement (see pages 36-37). Precertification is required, however, when Medicare hospital benefits are exhausted prior to using lifetime reserve days.
- You are confined in a hospital outside the United States and Puerto Rico.

Maternity or emergency admissions

When there is an unscheduled maternity admission or an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone 1-800-555-6600 or 301-251-4082 within two business days following the day of admission, even if the patient has been discharged from the hospital. Otherwise, inpatient benefits otherwise payable for the admission will be reduced by \$500. ~~Non-precertification in the first 72 hours following the date of admission for this admission is certified.~~

Other considerations

An early determination of need for confinement (precertification of the medical necessity of inpatient admission) is binding on the Carrier unless the Carrier is misled by the information given to it. After the claim is received, the Carrier will first determine whether the admission was precertified and then provide benefits according to all of the terms of this brochure.

If you do not precertify

If precertification is not obtained before admission to the hospital (or within two business days following the day of a maternity or emergency admission or, in the case of a newborn, the mother's discharge), a medical necessity determination will be made at the time the claim is filed. If the Carrier determines that the hospitalization was not medically necessary the inpatient hospital benefits will not be paid. However, medical supplies and services otherwise payable on an outpatient basis will be paid.

~~Each day you are hospitalized in excess of the number of days certified by the Carrier will be paid on an outpatient basis and~~

Precertification *continued*

Procedures that need to be precertified

The following list of outpatient procedures must be precertified by Optimum Choice, Inc., Utilization Management for appropriateness of setting and authorization. This step will help to determine the medical necessity for a treatment before the procedure is performed. The member, the member's attending physician, or any other person acting on the members behalf may contact Utilization Management at (800) 555-6600 or (301) 251-4082.

- Angiomas/Hemangioma Treatment
- Blepharoplasty
- Breast Implant Removal
- Breast Reconstruction
- Cataract Surgery
- Chiropractic Treatment
- Cholecystectomy By Laparoscopy
- Cochlear Implants
- Congenital Anomaly Repair
- Dialysis
- Growth Hormone Treatment
- Gynecomastia Surgery
- Hyperbaric Treatment
- Infertility Services
- Neurological - Psychological/Psychological Testing
- Non-Functional Abnormality Correction
- Outpatient Psychiatric Therapies, Including Psychiatric Day Treatment, Psychiatric Shock Treatment, And Substance Abuse Treatment
- Pelvic Laparoscopy
- Physical Therapy
- Radiation Therapy
- Reduction Mammoplasty
- Rhinoplasty
- Sclerotherapy
- Speech Therapy
- TMJ Pain Treatment
- Uvulopalatopharyngoplasty (UPPP)

Prescription drugs that need to be precertified

The following classifications of drugs need to be preauthorized by calling Optimum Choice, Inc. at (800) 555-6600 or (301) 251-4028:

- Myeloid Stimulants (brand name: Neupogen; generic name: Filgrastim)
- Erythroid Stimulants (brand name: Procrit; generic name: Epoetin Alfa)
- Interferon's (brand names: Intron A, Alferon N, Betaseron, and Actimmune; generic names: Interferon alfa-2b, interferon alfa-n3, interferon beta-1b, and interferon gamma-1b)
- Growth Hormones (brand names: Protropin, Nutropin; generic names: somatrem, Somatropin)
- Interleukins (brand name: Proleukin; generic name: aldesleukin (interleukin-2))
- Anti-infective Drugs (brand name: Mepron; generic name: Atovaquone)
- Oral Antifungal Drugs (Brand names: Diflucan, Sporanox and Lamisil; generic names: Fluconazole, itraconazole and terbinafine)
- Drugs for the treatment of infertility (brand names: Pergonal and Metrodin; generic names: menotropins and urofollitropin)
- CNS Stimulants and CNS/Autonomic Drugs (brand name: Cognex; generic name: tacrine)

This Plan and Medicare

Coordinating benefits

The following information applies only to enrollees and covered family members who are entitled to benefits from both this Plan and Medicare. You must disclose information about Medicare coverage, including your enrollment in a Medicare prepaid plan, to this Carrier; this applies whether or not you file a claim under Medicare. You must also give this Carrier authorization to obtain information about benefits or services denied or paid by Medicare when they request it. It is also important that you inform the Carrier about other coverage you may have as this coverage may affect the primary/secondary status of this Plan and Medicare.

This Plan covers most of the same kinds of expenses as Medicare Part A, hospital insurance, and Part B, medical insurance, except that Medicare does not cover prescription drugs.

The following rules apply to enrollees and their family members who are entitled to benefits from both an FEHB plan and Medicare.

This Plan is primary if:

- (1) You are age 65 or over, have Medicare Part A (or Parts A and B), and are employed by the Federal Government;
- (2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are employed by the Federal Government;
- (3) The patient (you or a covered family member) is within the first 18 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD) except when Medicare (based on age or disability) was the patient's primary payer on the day before he or she became eligible for Medicare Part A due to ESRD; or
- (4) The patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the Federal Government.

For purposes of this section, "employed by the Federal Government" means that you are eligible for FEHB coverage based on your current employment and that you do not hold an appointment described under Rule 6 of the following "Medicare is primary" section.

Medicare is primary if:

- (1) You are an annuitant age 65 or over, covered by Medicare Part A (or Parts A and B) and are not employed by the Federal Government;
- (2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are not employed by the Federal Government;
- (3) You are age 65 or over and (a) you are a Federal judge who retired under title 28, U.S.C., (b) you are a Tax Court judge who retired under Section 7447 of title 26, U.S.C., or (c) you are the covered spouse of a retired judge described in (a) or (b);
- (4) You are an annuitant not employed by the Federal Government, and either you or a covered family member (who may or may not be employed by the Federal Government) is under age 65 and eligible for Medicare on the basis of disability;
- (5) You are enrolled in Part B only, regardless of your employment status;
- (6) You are age 65 or over and employed by the Federal Government in an appointment that excludes similarly appointed nonretired employees from FEHB coverage, and have Medicare Part A (or Parts A and B);
- (7) You are a former Federal employee receiving workers' compensation and the Office of Workers Compensation has determined that you are unable to return to duty;
- (8) The patient (you or a covered family member) has completed the 18-month ESRD coordination period and is still eligible for Medicare due to ESRD; or
- (9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payer status for the patient under rules 1) through 7) above.

When Medicare is primary

When Medicare is primary, all or part of your Plan deductibles and coinsurance will be waived as follows:

Inpatient Hospital Benefits: If you are enrolled in Medicare Part A, the Plan will waive the deductible and coinsurance.

Surgical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance or copayment.

Mental Conditions and Substance Abuse: If you are enrolled in Medicare Part A, the Plan will

This Plan and Medicare *continued*

When Medicare is primary (cont'd)

waive the deductible and coinsurance for hospital charges for inpatient care. If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance or copayment for physicians' expenses for mental conditions. Lifetime maximums are not waived.

Other Medical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the copayment, deductible or coinsurance for other medical benefits. Plan maximums are not waived.

Additional Benefits: If you are enrolled in Medicare Part A, the Plan will waive the coinsurance or copayment for skilled nursing facility. If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance or copayment for routine physicals, and well child care. Plan maximums are not waived.

Prescription Drugs: If you are enrolled in Medicare Part B, the Plan will waive the copayment for Mail Order Prescription Drugs.

Dental Benefits: Coinsurance and deductibles will not be waived.

When Medicare is the primary payer, this Plan will limit its payment to an amount that supplements the benefits that would be payable by Medicare, regardless of whether or not Medicare benefits are paid. However, the Plan will pay its regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

When you also enroll in a Medicare prepaid plan

When you are enrolled in a Medicare prepaid plan while you are a member of this Plan, you may continue to obtain benefits from this Plan. If you submit claims for services covered by this Plan that you receive from providers that are not in the Medicare plan's network, the Plan will not waive any deductibles or coinsurance when paying these claims.

Medicare's payment and this Plan

If you are covered by Medicare Part B and it is primary, you should be aware that your out-of-pocket costs for services covered by both this Plan and Medicare Part B will depend on whether your doctor accepts Medicare assignment for the claim.

Doctors who participate with Medicare accept assignment; that is, they have agreed not to bill you for more than the Medicare-approved amount for covered services. Some doctors who do not participate with Medicare accept assignment on certain claims. If you use a doctor who accepts Medicare assignment for the claim, the doctor is permitted to bill you after the Plan has paid only when the Medicare and Plan payments combined do not total the Medicare-approved amount.

Doctors who do not participate with Medicare are not required to accept direct payment, or assignment, from Medicare. Although they can bill you for more than the amount Medicare would pay, Medicare law (the Social Security Act, 42 U.S.C.) sets a limit on how much you are obligated to pay. This amount, called the limiting charge, is 115 percent of the Medicare approved amount. Under this law, if you use a doctor who does not accept assignment for the claim, the doctor is permitted to bill you after the Plan has paid only if the Medicare and Plan payments combined do not total the limiting charge. Neither you nor your FEHB Plan is liable for any amount in excess of the Medicare limiting charge for charges of a doctor who does not participate with Medicare. The Medicare Explanation of Benefits (EOB) form will have more information about this limit.

If your doctor does not participate with Medicare, and asks you to pay more than the limiting charge and he or she is under contract with this plan, call the Plan. If your doctor is not a Plan doctor, ask the doctor to reduce the charge or report him or her to the Medicare carrier that sent you the Medicare EOB form. In any case, a doctor who does not participate with Medicare is not entitled to payment of more than 115 percent of the Medicare-approved amount.

How to claim benefits

In most cases, when services are covered by both Medicare and this Plan, Medicare is the primary payer if you are an annuitant and this Plan is the primary payer if you are an employee. When Medicare is the primary payer, your claims should first be submitted to Medicare. The Carrier has contracted with most Medicare Part B claims processors (also known as carriers) to receive electronic copies of your claims after Medicare has paid their benefits. This means you do not need to submit your Part B claims to the claims processor. Call the Carrier at 1-800/605-8202 or (301) 294-3777 to find out if your claims are being filed electronically. If they are not, you should initially submit your claims to Medicare. After Medicare has paid its benefits, the Carrier will consider the balance of any covered expenses. To be sure your claims are processed by this Carrier, you must submit the EOB form from Medicare and duplicates of all bills along with a completed claim form. The Carrier will not process your claim without knowing whether you have Medicare and, if you do, without receiving the Medicare EOB.

Enrollment Information

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Carrier. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Carrier. See "How to claim benefits".

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system (see Effective date on page 41).

Coverage under your new plan for a hospitalized member may be delayed if you are currently enrolled in another FEHB plan and you or a covered family member are hospitalized on the effective date of your enrollment; see If you are hospitalized below.

No FEHB plan may refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program except as stated in any cosmetic surgery or dental benefits description in this brochure.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance 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.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you provide you with an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan. If you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period.

Enrollment Information *continued*

- You will not be informed by your employing office (or your retirement system) or your Carrier when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Carrier does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Carrier promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.
Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay. You may also remain enrolled in this Plan when you join a Medicare prepaid plan. See page 37 for how this Plan's benefits are affected when you are enrolled in a Medicare prepaid plan.
Contact your local Social Security Administration (SSA) office for information on local Medicare plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.
- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separated from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement. Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Enrollment Information *continued*

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36-month period noted above.

Notification of Rights: Within 60 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

- **Children:** You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.
- **Former spouses:** You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices is available - or chosen - when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Definitions

Accidental injury

An injury caused by an external force such as a blow or fall and which requires immediate medical attention. Also included are animal bites, poisonings and dental care required as a result of an accidental injury to sound natural teeth. An injury to the teeth while eating is not considered an accidental injury.

Admission

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

Assignment

An authorization by an enrollee or spouse for the Carrier to issue payment of benefits directly to the provider. The Carrier reserves the right to pay the member directly for all covered services.

Calendar year

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

Congenital anomaly

A condition existing at or from birth which is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include protruding ear deformities, cleft lips, cleft palates, birthmarks, webbed fingers or toes and other conditions that the Carrier may determine to be congenital anomalies. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structures supporting the teeth.

Cosmetic surgery

Any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include but are not limited to:

- 1) personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;
- 2) homemaking, such as preparing meals or special diets;
- 3) moving the patient;
- 4) acting as companion or sitter;
- 5) supervising medication that can usually be self administered; or
- 6) treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

The Carrier determines which services are custodial care.

Durable medical equipment

Equipment and supplies that:

- 1) are prescribed by your attending doctor;
- 2) are medically necessary;
- 3) are primarily and customarily used only for a medical purpose;
- 4) are generally useful only to a person with an illness or injury;
- 5) are designed for prolonged use; and
- 6) serve a specific therapeutic purpose in the treatment of an illness or injury.

Effective date

The date the benefits described in this brochure are effective:

- 1) January 1 for continuing enrollments and for all annuitant enrollments;
- 2) The first day of the first full pay period of the new year for enrollees who change plans or options or elect FEHB coverage during the open season for the first time; or

For new enrollees during the calendar year, but not during the open season, the effective date of enrollment as determined by the employing office or retirement system.

Denfinitions *continued*

Experimental or investigational drug, device and medical treatment or procedure

A drug, device or medical treatment or procedure is experimental or investigational:

- 1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- 2) if reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- 3) if reliable evidence shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

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

Group health coverage

Health care coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies, or that pays a specific amount for each day or period of hospitalization if the specified amount exceeds \$200 per day, including extension of any of these benefits through COBRA. The Plan will coordinate benefits against the amount that exceeds \$200 per day.

Home health care agency

A public agency or private organization that is licensed as a home health care agency by the State, and is certified as such under Medicare.

Home health care

A plan of continued care and treatment of an insured person who is under the care of a doctor, and whose doctor certifies that without the home health care, confinement in a hospital or skilled nursing facility would be required.

Hospice care program

Professional inpatient and outpatient care rendered by a licensed or certified hospice to terminally ill patients for personal care and relief of pain using technical and related medical procedures. Initial emergency treatment is care rendered by a hospital or physician for an accidental injury. Initial emergency treatment does not provide benefits for ambulance transportation or treatment an enrollee receives as a result of an inpatient admission. Once the enrollee is admitted to the hospital, inpatient benefits will be applied.

Initial emergency treatment

Initial emergency treatment is care rendered by a hospital or a physician for an accidental injury. Initial emergency treatment does not provide benefits for ambulance transportation or treatment an enrollee receives as a result of an inpatient admission. Once the enrollee is admitted to the hospital, inpatient benefits will be applied.

Medical emergency

The sudden and unexpected onset of a condition requiring immediate non-surgical medical care which the covered person secures within 72 hours after the onset. The severity of the condition as revealed by the physician's diagnosis, must be such as would normally require emergency care. Medical emergencies include heart attacks, strokes, poisonings, loss of consciousness or respiration, convulsions, and such other acute conditions as may be determined by the Plan to be medical emergencies.

Denfinitions *continued*

Medically necessary

Services, drugs, supplies or equipment provided by a hospital or covered provider of the health care services that the Carrier determines:

- 1) are appropriate to diagnose or treat the patient's condition, illness or injury;
- 2) are consistent with standards of good medical practice in the United States;
- 3) are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
- 4) are not a part of or associated with the scholastic education or vocational training of the patient; and
- 5) in the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically necessary.

Mental conditions / substance abuse

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

Oral surgery

Surgery done on the roof or floor of the mouth, the tongue or the cheeks. Does not include surgery done on the teeth or supporting structures.

Reasonable and customary

The Plan allows benefits unless otherwise indicated, to the extent that they are reasonable and customary. The reasonable and customary charge for any non-PPO service or supply is the charge determined by the Plan on a semiannual basis to be in the 90th percentile of the prevailing charges made for a service or supply by providers in the geographic area where it is furnished. The prevailing charges data is obtained from prevailing health care charge guides such as that prepared by the Health Insurance Association of America (HIAA) and the Plan's administrator, Mid-Atlantic Medical Services, Inc. In determining the reasonable charge for a service or supply that is: unusual; or not often provided in the area; or provided by only a small number of providers in the area; the Plan may take into account factors, such as: the complexity; the degree of skills needed; the type of specialty of the provider; the range of services or supplies provided by a facility; and the prevailing charge in other areas. When a PPO provider is used, the fee that has been negotiated between the Plan and the PPO provider is considered the reasonable and customary charge.

Reconstructive surgery

Reconstructive surgeries are procedures required to restore the normal function of the body part, or to restore its appearance as it existed prior to an accidental injury, disease, or surgery. Examples include breast reconstruction and/or parallel adjustment following mastectomy. Reconstructive surgery to restore appearance alone is covered when the accidental injury, disease or surgery that resulted in the need for the reconstructive surgery occurred while the enrollee was a member of the FEHB Program.

Non-FEHB Benefits Available to Plan Members

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

BACE supplemental insurance plans

The following benefits may require additional premiums paid directly to BACE. Please contact the Plan for further details. Below is a brief description of all the supplemental insurance plans offered by BACE. For a complete explanation of any or all plans, please contact BACE.

Automatic membership coverage

Each actively employed member of BACE receives \$1,000 of Group Term Life insurance, \$50,000 Common Carrier Accidental Death and Dismemberment coverage, and \$10,000 Personal Automobile Accidental Death and Dismemberment coverage. This protection is automatic with membership. No premium payments are required.

NOTE: The automatic membership coverage underwritten by American Special Risk Management Corporation is non-contributory and is included with membership. No application or underwriting is required.

Group term life insurance plan

BACE members can substantially increase their life insurance portfolio by applying and being accepted for additional coverage under the Group Term Life insurance program. The BACE program allows each member to choose up to \$250,000 of life insurance protection at attractive group rates. Life insurance protection is also available for spouses and dependent children.

Disability income protection plan

The Disability Income Protection plan, specially designed to supplement the benefits provided under both the CSRS and FERS, provides four types of coverage including Hospital Income Protection, Long Term Disability, Pension Supplement and Survivor's Benefit. The Hospital Income Protection coverage is also available for dependents.

Personal accident insurance plan

Designed for those who travel frequently or who may have hazardous duty, the Personal Accident Insurance plan allows members the opportunity to increase their protection for up to \$250,000 at group rates. Protection is all risk, worldwide, twenty-four hours a day. Coverage is also available for family members as well.

Certain exclusions and eligibility requirements apply to each coverage.

The Group Term Life and Disability Income Protection plans, underwritten by AMEX Life Assurance Company, are subject to the underwriting requirements of AMEX Life. Coverages are not available to members residing in certain states.

Dental

BACE offers a supplemental dental plan to members residing in the Washington Metropolitan Area which complements the existing dental coverage provided in the BACE Health Plan. To receive substantial discounts on dental benefits you must select a participating dentist. This benefit will only be made available to you semiannually.

Vision

You and your family members can receive a discount from participating offices for eye examinations, contacts, frames, and lenses. This Plan is available only to members residing in the Washington Metropolitan Area.

Benefits on this page are not part of the FEHB Contract

How BACE Changes January 1998

Program wide changes

- This year, the OPM instituted minimum benefit levels in all plans for mastectomies (48 hours of inpatient care), normal deliveries (48 hours of inpatient care), and cesarean sections (96 hours of inpatient care). See pages 16 & 17 for plan benefits.
- North Dakota will not be included among the states designated as medically underserved in 1998. If you live in North Dakota this may affect your choice of provider. See page 6 for information on medically underserved areas.
- Members who are eligible for Medicare Part A benefits for the treatment of End Stage Renal Disease (ESRD) will now be covered by this plan for the first 30 months of eligibility before Medicare coverage begins. Prior to enactment of the Balanced Budget Act of 1997, Medicare picked up these benefits after 18 months.

Changes to this Plan

- Changes have been made under Mental Conditions / Substance Abuse benefits. See page 19 & 20.
- The plan now requires the precertification of certain outpatient procedures, services and prescription drugs. See page 35.
- The brochure has been clarified to stress that, in order to receive PPO benefits, your care must be provided by or coordinated through your Primary Care Physician.

Summary of Benefits for the BACE Health Benefit Plan - 1998

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). All items below with an asterisk (*) are subject to the \$250 calendar year deductible.

	Benefits	Plan pays / provides	Page
Inpatient care	Hospital	Optimum Choice PPO: 100% of covered charges after a \$150 per admission deductible Non-PPO: After the \$250 per admission deductible, 90% for semiprivate room and board charges and other hospital-billed services and supplies.	12, 13
	Surgical	Optimum Choice PPO: 100% of covered charges Non-PPO: 70%* of reasonable and customary.	14-16
	Medical	Optimum Choice PPO: 100% of covered charges Non-PPO: 70%* of reasonable and customary.	21-23
	Maternity	Optimum Choice PPO: 100% of covered charges Non-PPO: Same benefits as for illness or injury.	17, 18
	Mental conditions	Optimum Choice PPO: 100% of covered charges for 35 days; you pay a \$50 copayment per day up to \$300 per year. Non-PPO: After a \$500 deductible, 80% of covered charges up to 100 days per person per calendar year.	19, 20
	Substance abuse	Optimum Choice PPO: 100% of covered charges for 35 days; you pay a \$50 copayment per day up to \$300 per year. Non-PPO: Up to \$5,500 for one 30-day inpatient treatment program per calendar year (two programs per lifetime); Up to 7 days detoxification.	19, 20
Outpatient care	Hospital	Optimum Choice PPO: 100% of covered charges Non-PPO: 70%* of reasonable and customary charges for preadmission testing and related outpatient services rendered on the day of surgery.	12, 13
	Surgical	Optimum Choice PPO: 100% of covered charges, you pay a \$10 copayment Non-PPO: 70%* of reasonable and customary charges.	14-16
	Medical	Optimum Choice PPO: 100% of covered charges, you pay a \$10 copayment Non-PPO: 70%* of reasonable and customary charges.	21-23
	Maternity	Optimum Choice PPO: 100% of covered charges, you pay \$10 copayment Non-PPO: Same benefits as for illness or injury.	17, 18
	Home health care	Optimum Choice PPO: 100% of covered charges Non-PPO: Up to \$40 per visit for up to 40 home health care visits in a calendar year.	24
	Mental conditions	Optimum Choice PPO: 75% of covered charges up to 40 visits Non-PPO: 50%* limited to a maximum payable of 20 visits per person per calendar year	19, 20
	Substance abuse	Optimum Choice PPO: 75% of covered charges up to 40 visits Non-PPO: 50%* limited to a maximum payable of 20 visits per person per calendar year.	19, 20
Emergency care (Accidental injury)	Optimum Choice PPO: 100% of covered charges after a \$10 member copayment at a participating urgent care center; and a \$25 member copayment for covered charges at a non-participating urgent care center Non-PPO: 100% of reasonable and customary charges for initial care; you pay \$25 copayment.	24	
Prescription drugs		26, 27	
	Prescription card program:	After a \$50 deductible per covered family member, 100%; you pay a \$10 copayment per prescription except when a name brand drug is requested when a generic equivalent is available; then you pay the difference in cost plus the copayment.	
	Mail order program:	100%; you pay a \$10 copayment per prescription or refill except when a name brand drug is requested when a generic equivalent is available; then you pay the difference in cost plus the copayment.	
Dental care	Dental services as listed on fee schedule	28, 29	
Additional benefits	Hospice care, well child care, skilled nursing facility	24, 25	
Protection against catastrophic costs	100% of covered charges after out-of-pocket expenses for Other Medical Benefits and other charges under Inpatient Hospital Benefits, excluding the calendar year deductible, exceed \$3,000 per person or \$3,000 for family per calendar year	33	
	Mental conditions	80% of covered charges after your out-of-pocket expenses for inpatient confinements exceed \$8,000 including \$500 deductible per calendar year subject to a \$50,000 annual maximum	33