Section 5. Benefits -- OVERVIEW

(See page xx for how our benefits changed this year and page xx for a benefits summary.)

NOTE: This benefits section is broken into subsections. Please read the important things you should keep in mind at the beginning of each subsection. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at *{phone number}* or at our website at www.{insert *web address}*.

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SUMMARY OF BENEFITS ..... xx *{page # from summary at back of brochure}*

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: *{plan specific}* $275 per person ($550 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. *{If you want, you can say, "We added asterisks - * - to show when the calendar year deductible does not apply."}*
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians • In physician's office	PPO: $15 copayment (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion • At home	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Routine physical checkups and related tests	*All charges*

Lab, X-ray and other diagnostic tests	You pay
Laboratory tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	PPO: $5 copayment (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount *{describe benefits using plan allowance instead of R&C, etc}* Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges. *{standard paragraph}*
Preventive care, adult	
Routine screenings, limited to: • Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including •• Fecal occult blood test	PPO: $x copayment (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount
•• Sigmoidoscopy, screening – every five years starting at age 50	PPO: 15% of the Plan allowance Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	PPO: $25 copayment (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount
Routine pap test Note: The office visit is covered if pap test is received on the same day; see Diagnosis and Treatment, above.	PPO: Nothing for first $35 in charges (No deductible), then xx% of the Plan allowance Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	PPO: $25 copayment (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount

Preventive care, adult - Continued on next page

Preventive care, adult - *Continued*	**You pay**
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	PPO: $x copayment (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount
Not covered:	*All charges.*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	PPO: Nothing (No deductible) Non-PPO: Nothing (No deductible)
• For well-child care charges for routine examinations, immunizations and care (to age 3)	PPO: Nothing (No deductible) Non-PPO: Nothing (No deductible)
• Examinations, limited to: •• Examinations for amblyopia and strabismus – limited to one screening examination (ages 2 through 6) •• Examinations done on the day of immunizations (ages 3 through 22)	PPO: $15 copayment (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page xx for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you must precertify.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Maternity care -- Continued on next page.

Maternity care - *Continued*	**You pay**
• Routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	*(see above)*
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) Note: We cover contraceptive drugs in Section 5(f).	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: reversal of voluntary surgical sterilization, genetic counseling,	*All charges.*
Infertility services	
Diagnosis and treatment of infertility, except as excluded.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Fertility drugs* • *Assisted reproductive technology (ART) procedures, such as:* •• *artificial insemination* •• *in vitro fertilization* •• *embryo transfer and GIFT* •• *intravaginal insemination (IVI)* •• *intracervical insemination (ICI)* •• *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures.*	*All charges.*

Allergy care	You pay
Testing and treatment, including materials (such as allergy serum)	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Allergy injection	PPO: $x copayment each (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page xx. • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: – We only cover GHT when we preauthorize the treatment. *{Plan specific; summarize instructions on how to get authorization -- here is one plan's example}* Call xxx for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3. • Respiratory and inhalation therapies	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered:	*All charges.*
Rehabilitative therapies	
Physical therapy, occupational therapy, and speech therapy – • 90 visits per calendar year for the services of each of the following: •• qualified physical therapists; •• speech therapists; and •• occupational therapists.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Rehabilitative therapies - Continued on next page

Rehabilitative therapies	You pay
Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury and when a physician: 1) orders the care; 2) identifies the specific professional skills the patient requires and the medical necessity for skilled services; and 3) indicates the length of time the services are needed. *{definition is standard}*	
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*
Hearing services (testing, treatment, and supplies)	
First hearing aid and testing only when necessitated by accidental injury	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *hearing testing* • *hearing aids, testing and examinations for them, except for accidental injury*	*All charges.*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) Note: See Preventive care, children for eye exams for children	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses and examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges.*

Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	PPO: $15 copayment for the office visit (No deductible) plus xx% of the Plan allowance for other services performed during the visit Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*. All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy *{{Plan – if you pay for devices here, use this language:}}* • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
{Plan – if you pay for devices under hospital benefits, use this language:} • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5 (c) for payment information. Insertion of the device is paid as surgery; see Section 5(b).	
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges.*

Durable medical equipment (DME)	You pay
{use this standard benefit description } Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment, such as oxygen and dialysis equipment. Under this benefit, we also cover: *{List plan specific}* • Hospital beds; • Wheelchairs;*{show what you do cover here, and what you don't, below}}* • Crutches; and • Walkers. Note: Call us at xxx as soon as your physician prescribes this equipment. We arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
• *Not covered: {Plan specific}*	*All charges*
Home health services	
90 days per calendar year up to a maximum plan payment of $75 per day when: • A registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) provides the services; • The attending physician orders the care; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • The physician indicates the length of time the services are needed.	PPO: 20% (No deductible); all charges after we pay $75 per day Non-PPO: 20% (No deductible); all charges after we pay $75 per day
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges.*

Alternative treatments	You pay
Acupuncture – by a doctor of medicine or osteopathy for: anesthesia, pain relief,	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • Chiropractic services • *naturopathic services* (Note: benefits of certain alternative treatment providers may be covered in medically underserved areas; see page ___)	. *All charges*
Educational classes and programs	
Coverage is limited to: • Smoking Cessation – Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. • Diabetes self management.	PPO: Nothing Non-PPO: Nothing

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $275 per person ($550 per family). The calendar year deductible applies to almost all benefits in this Section. We added "No deductible" to show when the calendar year deductible does not apply. *{If you want, you can say, "We added asterisks - * - to show when the calendar year deductible does not apply."}*
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Any costs associated with the facility charge (i.e. hospital, surgical center, etc.) are in Section 5 (c).
- **YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification. *{Plan specific; identify which surgeries require pecertification – delete if not applicable}***

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply. *{Plan-can say "We added asterisks -* - when it does not apply"}*	
Surgical procedures	
• Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Electroconvulsive therapy	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - Continued on next page.

Surgical procedures - *Continued*	**You pay**
• Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over *{Use this standard definition if you need to define it; put your limits, if any, etc}* • Insertion of internal prostethic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information • Voluntary sterilization, Norplant (a surgically implanted contraceptive), and intrauterine devices (IUDs) • Treatment of burns • Assistant surgeons- we cover up to 25% of our allowance for the surgeon's charge	PPO: 15% of the Plan allowance for the primary procedure and 15% of one-half of the Plan allowance for the secondary procedure(s) Non-PPO: 30% of the Plan allowance for the primary procedure and 30% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure: •• PPO: 85% of the Plan allowance or •• Non-PPO: 70% of the reasonable and customary charge • For the secondary procedure(s): •• PPO: 85% of one-half of the Plan allowance or •• Non-PPO: 70% of one-half of the reasonable and customary charge Note: Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures. *{describe this way if applies}*	PPO: 15% of the Plan allowance for the primary procedure and 15% of one-half of the Plan allowance for the secondary procedure(s) Non-PPO: 30% of the Plan allowance for the primary procedure and 30% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary* • *Routine treatment of conditions of the foot; see Foot care*	*All charges.*

Reconstructive surgery	You pay
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery *{use this standard description}* • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformaties; cleft lip; cleft palate; birth marks; and webbed fingers and toes. *{use this standard definition}* • All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage)	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Note: Internal breast prostheses are paid as hospital benefits. Note: 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. *{standard}*	
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury if repair is initiated within {insert negotiated limit, if any}* • *Surgeries related to sex transformation or sexual dysfunction*	All charges

Oral and maxillofacial surgery	You pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – only for the following end-stage pulmonary diseases: primary fibrosis, primary pulmonary hypertension, or emphysema; Double – only for patients with cystic fibrosis • Pancreas • Allogeneic bone marrow transplants – only for patients with acute leukemia, advanced Hodgkins disease *{Insert ABMT benefits from 2000 brochure}* National Transplant Program (NTP) - ….*{plan specific here}* Limited Benefits - …*{Plan specific}* Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	*{{Plan specific -- for national transplant program or other special programs, etc, refer back to the page you explain it on.}*
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Anesthesia	You pay
Professional services provided in – • Hospital (inpatient)	PPO: 15% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for any anesthesia charges.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Unlike Sections (a) and (b), in this section the calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)". ***{Plan – be sure to notice this is a different bullet}***
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay
NOTE: The calendar year deductible applies ONLY when we say below: "calendar year deductible applies".	
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, we base our payment on the average semiprivate rate of the most comparable hospital in the area. NOTE: When the non-PPO hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.	PPO: Nothing Non-PPO: $100 per admission and 20% of the covered charges Note: If you use a PPO provider and a PPO facility, we may still pay non-PPO benefits if you receive treatment from a radiologist, pathologist, or anesthesiologist who is not a PPO provider. PPO: Nothing Non-PPO: 20% of charges

Inpatient hospital - Continued on next page.

Inpatient hospital - *Continued*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) NOTE: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay Hospital benefits and when the anesthesiologist bills, we pay Surgery benefits.	(see above)
Not covered: • *Any part of a hospital admission that is not medically necessary (see definition), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting* • *Custodial care; see definition.* • *Non-covered facilities, such as nursing homes, extended care facilities, schools, {Plan specific}* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	PPO: 15% of Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered:	*All charges.*

Extended care benefits/Skilled nursing care facility benefits	You pay
Skilled nursing facility (SNF): We cover semiprivate room, board, services and supplies in a SNF for up to 30 days per confinement when: 1) you are admitted directly from a precertified hospital stay of at least 3 consecutive days; and 2) you are admitted for the same condition as the hospital stay; and 3) your skilled nursing care is supervised by a physician and provided by an R.N., L.P.N., or L.V.N.; and 4) SNF care is medically appropriate.	PPO: Nothing Non-PPO: • Room and board -Nothing • Other charges- 20% of the Plan allowance and any difference between our allowance and the billed amount
Extended care benefit: *{insert benefit}*	
{Plan -- if extended care and skilled nursing are the same in your plan, only show one block and describe your benefit.}	
Not covered: Custodial care	*All charges.*
Hospice care	
Definition: Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. • We pay $3000 per lifetime for inpatient and outpatient services.	PPO: 15% of Plan allowance until benefits stop at $3000 Non-PPO: 30% of Plan allowance (and any difference between our allowance and the billed amount) until benefits stop at $3000
Not covered: Independent nursing, homemaker	*All charges.*
Ambulance	
• Local professional ambulance service when medically appropriate	PPO: 15% of Plan allowance Non-PPO: 30% of Plan allowance and any difference between our allowance and the billed amount

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The calendar year deductible is: *{plan specific}* $275 per person ($550 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. *{If you want, you can say, "We added asterisks - * - to show when the calendar year deductible does not apply."}*.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

~~What is accidental injury/medical emergency~~? *{STET for FFS that have special benefits for medical emergency.}*

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

What is an accidental injury?

An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, and poisonings. We do not cover dental care for accidental injury. *{Plan specific}*

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply. *{Or: We added an asterisk -* - when it does not apply.}*	
Accidental injury	
If you receive care for your accidental injury within 48 hours, we cover: • Non-surgical physician services and supplies • Related outpatient hospital services Note: We pay Hospital benefits if you are admitted.	PPO: Nothing (No deductible) Non-PPO: Only the difference between our allowance and the billed amount *{This example should work any time you pay 100% of your allowance}*

Accidental injury -- Continued on next page

Accidental injury *(Continued)*	**You pay**
If you receive care for your accidental injury after 48 hours, we cover: • Non-surgical physician services and supplies • Surgical care Note: We pay Hospital benefits if you are admitted.	PPO: 15% of Plan allowance Non-PPO: 30% of Plan allowance and any difference between our allowance and the billed amount
Medical emergency	
Outpatient medical or surgical services and supplies	PPO: 15% of Plan allowance Non-PPO: 30% of Plan allowance and any difference between our allowance and the billed amount *{Plan -- If you do not have a special benefit for medical emergencies, describe your regular benefits}*
Ambulance	
Professional ambulance service Note: See 5© for non-emergency service.	PPO: 15% of Plan allowance Non-PPO: 30% of Plan allowance and any difference between our allowance and the billed amount
Not covered: air ambulance {{if covered, show above}}	*All charges*

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

Network Benefit

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

- Please remember that these benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are clinically appropriate to treat you condition.
- See page xx for Out-of-Network benefits.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Description	You Pay
Network mental health and substance abuse benefits	
We will cover services for the treatment of mental health and substance abuse conditions recommended by a network provider contained in a treatment plan that we approve. For example, this can include: • services by providers such as psychiatrists, psychologists, or clinical social workers, • any diagnostic tests that they order, • any facilities that they admit you to, or • any drugs that are prescribe for your condition. In some cases, our network providers may refer you to community based programs if they are appropriate to treat your condition, such as self-help groups or 12 step programs.	Cost sharing and limitations for benefits that we cover (for example, visit/day limits, deductibles, coinsurance, copayments, and out-of-pocket maximums) for mental health and substance abuse are based on the cost sharing and limits for similar benefits under our network medical, hospital, prescription drug, diagnostic testing, and surgical benefits. For example, the same copayment or coinsurance that applies when you visit a specialist for a physical illness or disease applies to a visit to a mental health or substance abuse provider for a therapy session. You will pay the same copayment or coinsurance for a prescription drug to treat a mental health or substance abuse condition as you would for a prescription to treat a physical illness or disease.
Not covered in the network: The same exclusions contained in this brochure that apply to other benefits apply to these mental health and substance abuse benefits, unless the services are included in a treatment plan that we approve. OPM's review of disputes about network treatment plans will be based on the treatment plan's clinical appropriateness. OPM will generally not order one clinically appropriate treatment plan in favor of another.	*All charges.*

Network mental health and substance abuse benefits -- Continued on next page.

Preauthorization

To be eligible to receive these enhanced mental health and substance abuse benefits you must follow your treatment plan and all of our network authorization processes. These include:

- *{insert network entry procedures, phone numbers, referral procedures, network restrictions, how to identify providers and obtain provider directories, inpatient and outpatient treatment plan approval procedures}*

Network deductibles and out-of-pocket maximums

{Insert Network deductible and out-of-pocket maximum policies}

{About the special transitional benefit below: Your contract specialist will work with you to decide which bullets listed below apply to your plan. FFS plans that had no network mental health or substance abuse providers in 2000 and are not reducing out-of-network benefits in 2001 can delete this section.)

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause, or *{{add this bullet to HMO or POS brochures or a FFS plan that had network mental health and substance abuse providers in 2000}*
- If changes to this plan's benefit structure for 2001 cause your out-of-pocket costs for your out-of-network provider to be greater than they were in contract year 2000. *{add this bullet to FFS or POS brochures only if the Plan had an increase in out-of-network member cost sharing}*

If these conditions apply to you, *{or, If this condition applies to you,}* we will allow you reasonable time to transfer your care to a network mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage. The transitional period will last for up to 90 days from the date you receive notice of the change. You may receive this notice prior to January 1, 2001, and the 90 day period begins with receipt of the notice.

Network limitation

We may limit your benefits if you do not follow your treatment plan.

How to submit network claims

{Insert claims process for in-Network claims}

Out-of-Network Benefit

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- See page xx for In-Network benefits.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Description	You Pay
Out-of-Network mental health and substance abuse benefits	
{ insert your year 2000 mental health and substance abuse benefits}	*(Insert year 2000 cost sharing)*
Not covered out-of-network: {Insert year 2000 mental health and substance abuse exclusions}	*All charges.*

Out-of-Network mental health and substance abuse benefits -- Continued on next page.

Out-of-Network Benefit - *CONTINUED*

Precertification	*{Insert precertification requirements}*
Out-of-Network Out-of-Pocket Maximums	*{Insert out-of-network out-of-pocket maximum policy.}*
How to submit Out-of-Network claims	*{Insert process for submitting out-of-network claims}*

Section 5 (f). Prescription drug benefits

IMPORTANT

{This block and all headers are standard; you add text}

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $275 per person ($550 per family). The calendar year deductible applies to almost all benefits in this Section. We added "No deductible" to show when the calendar year deductible does not apply. *{If you want, you can say, "We added asterisks - * - to show when the calendar year deductible does not apply."}*
- *{{If you have a prescription deductible, describe it here; also describe any prior authorization requirements.}}*
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

- **Who can write your prescription.** A licensed physician must write the prescription – or – A plan physician or licensed dentist must write the prescription {*plan specific}*.
- **Where you can obtain them.** You may fill the prescription at a xxx pharmacy, a non-network pharmacy, or by mail. We pay a higher level of benefits when you use a network pharmacy. – or – You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication *{Plan specific -- any time you have different rules/benefits for mail order, pharmacy, etc., break them out in bullets. For each, describe issues that are problematic, e.g., if your mail order firm doesn't cover all drugs}.*
- **We use a formulary.** *{Plan specific -- make it very clear if you use a formulary. Include an explanation of just exactly what a formulary is and what happens if the provider prescribes something that is not on the formulary. If you don't use a formulary, don't add this paragraph}}*
- **These are the dispensing limitations.** *{Plan specific. Please include information on day limitations for both retail and mail-order and prior approvals, copay differences, etc. Also explain that not everything is available via mail order -- and explain why. Show if you follow FDA dispensing guidelines. Show what will happen if the member sends in an order too soon after the last one was filled. Describe if multiple copays for same prescription -- explain well that member pays for each one.} {Be sure to show that if there is no generic equivalent available, member will still have to pay the brand name copay -- if that is the case; if it isn't, explain}***When you have to file a claim.** *{Plan specific}.*

Prescription drug benefits begin on next page.

Benefit Description	You Pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply. *{or: We added asterisks -*- when it does not apply.}*	
Covered medications and supplies	
Each new enrollee will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope. You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail: • *Plan specific – based on what a plan lists in 2000 under "what is covered"* • Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below • Insulin • Needles and syringes for the administration of covered medications • Contraceptive drugs and devices Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified "dispense as written" for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. We administer an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call xxx.	• Network Retail: $5 generic/$10 brand name • Network Retail Medicare: $1 generic/$2 brand (No deductible) • Non-Network Retail: 40% of cost • Non-Network Retail Medicare: 40% of cost (No deductible) • Network Mail Order: $12 generic/$25 brand • Network Mail Order Medicare: $2 generic/$4 brand (No deductible) Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines*	*All Charges*

Section 5 (g). Special features

Special features	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. ***{This benefit description is standard}***
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-800-622-6252 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	
Reciprocity benefit	
High risk pregnancies	
Centers of excellence for transplants/heart surgery/etc	
Travel benefit/ services overseas	

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: *{plan specific}* $275 per person ($550 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. *{If you want, you can say, "We added asterisks - * - to show when the calendar year deductible does not apply."}. {If HMO – if you don't have deductible, remove this check mark or say "We have no calendar year deductible.}*
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure.

IMPORTANT

Accidental injury benefit

We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. You pay _____

Dental benefits

We have no other dental benefits.

{{Or, if you have dental benefits and you have a fee scheduled use this format/table:}}

Dental benefits		
Service	**We pay (scheduled allowance)**	**You pay**
Office visits *{List services you cover}*	$___ per $___ per	All charges in excess of the scheduled amounts listed to the left

{{If you have dental HMO benefits use this format/table:}}

Dental benefits	
Service	**You pay**
{list services you cover}	$xxx

Section 5 (i). Point-of-Service benefits

{Describe your point-of-service benefits. If you don't have any, or don't describe them here, remove this section and renumber the next section to 5(I). Be sure to add all that apply of the IMPORTANT bullets at the start of the section.}