# 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}.*

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

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.
- Plan physicians must provide or arrange your care.
- 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. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

| Benefit Description | You pay<br>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.** *{Delete the row if you don't' have a deductible.}* | |
| **Diagnostic and treatment services** | |
| Professional services of physicians<br>• In physician's office | $10 per visit<br>***{Minimum copay for primary care office visit is $10 per 2000 negotiations.}***<br>*{{When you have different copay for primary care and specialty care, say:*<br>$10 per visit to your primary care physician<br>$5 per visit to a specialist |
| Professional services of physicians<br>• In an urgent care center<br>• During a hospital stay<br>• In a skilled nursing facility*{plan specific}*<br>• Initial examination of a newborn child covered under a family enrollment<br>• Office medical consultations<br>• Second surgical opinion | $10 per visit |
| At home {***House calls are a required benefit for individual practice and mixed model prepayment plans under section 8903(4)(B), Chapter 89 of title 5, U.S.C. If Plan is classified as a Group Practice Plan and does not provide house calls under any circumstances, omit this language. }*** | Nothing |

*Diagnostic and treatment services -- Continued on next page*

| **Diagnostic and treatment services** *(Continued)* | **You pay** |
|---|---|
| *Not covered: {* ***remove this section if it does not apply}***<br><br>***{You may NOT exclude the following, per HCFA's Office of Managed Care 12/4/84:***<br>***{· Vaccines for pediatric and adult immunizations***<br>***{· Nondental treatment of temporomandibular joint(TMJ) syndrome***<br>***{· Services for which a member has no responsibility to pay***<br>***{· Services for intentionally inflicted injuries***<br>***{· Services for injuries resulting from hazardous activities***<br>*{· Injuries received in connection with the commission of a felony}* | ***All charges.*** |
| **Lab, X-ray and other diagnostic tests** | |
| Laboratory tests, such as:<br>• Blood tests<br>• Urinalysis<br>• Non-routine pap tests<br>• Pathology<br>• X-rays<br>• Non-routine Mammograms<br>• Cat Scans/MRI<br>• Ultrasound<br>• Electrocardiogram and EEG | Nothing if you receive these services during your office visit; otherwise, $10 per visit<br><br>***{ Normally there is not a copay for these services when received during an office visit. Please modify to show the plan's benefit.}*** |
| **Preventive care, adult** | |
| Routine screenings, such as: *{—add whatever benefits you want to add but keep these as a minimum; new boxes when the costs are different; same box if same cost.}*<br>• Blood lead level – One annually<br>• Total Blood Cholesterol – once every three years, ages 19 through 64<br>• Colorectal Cancer Screening, including<br>••Fecal occult blood test | $10 per visit |
| ••Sigmoidoscopy, screening – every five years starting at age 50 | $10 per visit |
| Prostate Specific Antigen (PSA test) – one annually for men age 40 and older | $10 per visit |
| Routine pap test<br><br>Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment*, above. | $10 per visit |

| **Preventive care, adult** *(Continued)* | **You pay** |
|---|---|
| Routine mammogram –covered for women age 35 and older, as follows:<br>• From age 35 through 39, one during this five year period<br>• From age 40 through 64, one every calendar year<br>• At age 65 and older, one every two consecutive calendar years | $10 per visit<br>***{All FEHB plans will follow the recommendations of the National Cancer Advisory Board for the provision of mammogram at a minimum. Modify to reflect plan benefit.}*** |
| *Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* | *All charges.*<br>***{This exclusion is not required under the FEHB but we expect it applies to most plans and prefer this language. It is not intended to exclude periodic physical exams or check-ups; we consider these to be preventive care.}*** |
| Routine Immunizations, limited to:<br>• Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations)<br>• Influenza/Pneumococcal vaccines, annually, age 65 and over | $10 per visit<br>*{You may not charge coinsurance or copays for immunizations; copays may apply to associated visits however.}* |
| **Preventive care, children** | **You pay** |
| • Childhood immunizations recommended by the American Academy of Pediatrics | $10 per visit |
| • Examinations, such as:<br>••Eye exams through age 17 to determine the need for vision correction.<br>••Ear exams through age 17 to determine the need for hearing correction<br>••Examinations done on the day of immunizations ( through age 22)<br>• Well-child care charges for routine examinations, immunizations and care (through age 22) | $10 per visit<br>***{"Eye and ear examinations for children through age 17, to determine the need for vision and hearing correction" are basic services required of Federally-qualified plans.}*** |

| Maternity care | You pay |
|---|---|
| Complete maternity (obstetrical) care, such as:<br>• Prenatal care<br>• Delivery<br>• Postnatal care<br>Note: Here are some things to keep in mind:<br>• You do not need to precertify your normal delivery; see page xx for other circumstances, such as extended stays for you or your baby.<br>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.<br>• Routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment.<br>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). | $10 per visit<br>***{We encourage you to provide incentives for prenatal care, e.g., copay waivers. Some plans may apply a single copay for the entire pregnancy, if you do, say that here. The maternity stay requirement reflects Title VI of Public Law 104-204, the Newborns' and Mothers' Health Protection Act of 1996".}***<br>***{Definitive treatment for purposes of your benefit: "Treatment of a disease or disorder that includes everything . . . necessary to attain a cure or the best results possible under the circumstances."}*** |
| *Not covered: Routine sonograms to determine fetal age, size or sex* | *All charges* |
| **Family planning** | |
| • Voluntary sterilization<br>• Surgically implanted contraceptives<br>• Injectable contraceptive drugs<br>• Intrauterine devices (IUDs)<br>***{"A broad range of voluntary family planning services" is one of the basic health services mandated for Federally-qualified plans. Modify benefit description to describe Plan benefit. Copays or coinsurance may apply. Voluntary abortions may not be covered. Coinsurance or copays may apply to surgical procedures.}*** | $10 per visit |
| *Not covered: reversal of voluntary surgical sterilization, genetic counseling,* | *All charges.* |

| Infertility services | You pay |
|---|---|
| Diagnosis and treatment of infertility, such as:<br>• Artificial insemination:<br>••*intravaginal insemination (IVI)*<br>••*intracervical insemination (ICI)*<br>••*intrauterine insemination (IUI)*<br>• Fertility drugs<br>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.<br>***{Services for the treatment of infertility, including at least one type of artificial insemination, are basic services required of Federally-qualified HMOs and may not be limited as to time and cost.. Coinsurance may apply and you may limit the number of procedures based on standards of accepted medical practice, per the fourth General Exclusion. You may cover the cost of donor sperm; we do not require that you exclude this benefit. Clarify the coverage of fertility drugs and, if covered, whether they are covered as prescription drugs. Expanded coverage, e.g., ART, is required in several states. We expect you to cover state-mandated benefits whether or not they are specifically referenced in a plan's community package. In that case, modify the language to reflect Plan benefits.}*** | $10 per visit |
| *Not covered:*<br>• *Assisted reproductive technology (ART) procedures, such as:*<br>••*in vitro fertilization*<br>••*embryo transfer and GIFT*<br>• *Services and supplies related to excluded ART procedures*<br>• *Cost of donor sperm* | *All charges.* |
| **Allergy care** | |
| Testing and treatment<br>Allergy injection<br>***{Allergy testing and treatment are required benefits for all Federally-qualified HMOs, and therefore FEHB HMOs. You must cover allergy serum in full.}*** | $10 per visit |
| Allergy serum | Nothing |
| *Not covered: provocative food testing and sublingual allergy desensitization* | *All charges.* |

| Treatment therapies | You pay |
|---|---|
| • Chemotherapy and radiation therapy<br><br>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page xx.<br><br>• Respiratory and inhalation therapy<br><br>• Dialysis – Hemodialysis and peritoneal dialysis<br><br>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy<br><br>• Growth hormone therapy (GHT)<br><br>Note: – We will only cover GHT when we preauthorize the treatment. *{Plan specific--IF YOU HAVE SUCH REQUIREMENT; 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.<br><br>***{Growth Hormone therapy is a required benefit for all plans. Note whether it is covered under the plan's prescription drug benefit or under medical..}***<br><br>***{Radiation therapy and inhalation therapy are basic health services required of federally-qualified plans and therefore of FEHB plans, starting in 1990. For this reason, they must be provided without limitations as to time and cost. As respiratory therapy includes inhalation therapy, we will not permit respiratory therapy to be subject to limitations of time and cost.}*** | $10 per visit |
| *Not covered:* | *All charges.* |

| Rehabilitative therapies | You pay |
|---|---|
| Physical therapy, occupational therapy and speech therapy --<br>• 60 visits per condition for the services of each of the following:<br>••qualified physical therapists;<br>••speech therapists; and<br>••occupational therapists.<br>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.<br>***{The required benefit level is up to two consecutive months per condition. A plan may provide a richer benefit, such as 60 visits per condition, if that is their community benefit. The word "condition" is part of the benefit description for Federally-qualified plans and must be retained. Copays or coinsurance of up to 50% may apply}***<br>• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 00 sessions<br>*{Cardiac rehabilitation is n****ot a required benefit but a desirable one covered by many plans. If not covered, list as an exclusion. Modify language to fit the Plan's benefit.}*** | $10 per visit |
| *Not covered:*<br>• *long-term rehabilitative therapy*<br>• *exercise programs* | *All charges.* |
| **Hearing services (testing, treatment, and supplies)** | |
| • First hearing aid and testing only when necessitated by accidental injury<br>• Hearing testing for children through age 17 (see *Preventive care, children*) | $10 per visit |
| *Not covered:*<br>• *all other hearing testing*<br>• *hearing aids, testing and examinations for them* | *All charges.* |

| Vision services (testing, treatment, and supplies) | You pay |
|---|---|
| *{insert any vision care benefit from 2000 brochure}* | |
| • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) | $10 per visit |
| • Eye exam to determine the need for vision correction for children through age 17 (see preventive care)<br>• Annual eye refractions<br>***{Modify to reflect plan benefit. Like Dental care, we will accept proposals for Vision care only when the benefit is an integral part of the community package.}***<br>***{We encourage plans offering new vision or dental benefits that are <u>not</u> part of the community package to describe them on the non-FEHB page of the brochure.}*** | $10 per visit |
| *Not covered:*<br>• *Eyeglasses or contact lenses and, after age 17, examinations for them*<br>• *Eye exercises and orthoptics*<br>• *Radial keratotomy and other refractive surgery* | *All charges.* |
| **Foot care** | |
| Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.<br>See orthopedic and prosthetic devices for information on podiatric shoe inserts. | $10 per visit |
| *Not covered:*<br>• *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*<br>• *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 | You pay |
|---|---|
| ***{Not a required benefit; However, all plans must cover breast prostheses and surgical bras including necessary replacements following a mastectomy.}***<br><br>***{Modify language to describe Plan benefits and note any exclusions or specific type of coverage e.g. standard artificial limbs, or if plan will cover upgrades up to cost of standard device.}***<br><br>• Artificial limbs and eyes; stump hose<br><br>• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy<br><br>*{If you pay for devices in this section, use the following language:}*<br><br>• 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.<br><br>*{If you pay for devices under hospital benefits, use the following language:}*<br><br>• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device.<br><br>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. | $10 per visit |
| *Not covered:*<br><br>• *orthopedic and corrective shoes*<br><br>• *arch supports*<br><br>• *foot orthotics*<br><br>• *heel pads and heel cups*<br><br>• *lumbosacral supports*<br><br>• *corsets, trusses, elastic stockings, support hose, and other supportive devices*<br><br>• *prosthetic replacements provided less than 3 years after the last one we covered* | *All charges.* |

| Durable medical equipment (DME) | You pay |
|---|---|
| ***{ Not a required benefit; If you don't cover any, show "No benefit" in the benefit description and You Pay column.}***<br><br>***{Modify language to describe Plan benefits and note any DME exclusions, e.g., motorized wheel chairs. If any are not covered, list under "Not covered".}***<br><br>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: *{List plan speciifc}*<br><br>• hospital beds;<br>• wheelchairs; *{If you don't cover a certain kind of wheelchair, you need to show what you do cover here, and what you don't, below}*<br>• crutches;<br>• walkers;<br>• blood glucose monitors; and<br>• insulin pumps.<br><br>Note: Call us at xxx as soon as your Plan physician prescribes this equipment. We will 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. *{add this kind of note if you offer this type of enhancement}* | $10 per visit |
| *Not covered:*<br>• *Motorized wheel chairs*<br>• | *All charges.* |
| **Home health services** | |
| • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. *{You must cover home health aide for this.}*<br><br>• Services include oxygen therapy, intravenous therapy and medications.<br><br>***{Home health services are a required benefit. Federally-qualified HMOs are required to provide "Home health services provided at a member's home by health care personnel, as prescribed or directed by the responsible physician or other authority designated by the HMO." Modify the language to describe the staff used by the Plan to provide these services. These are basic benefits and may not be subject to dollar or day limitations. If a copay applies, reference under you pay or show Nothing. Outpatient benefits provided only in conjunction with home health care, e.g., oxygen therapy, should be described here. Coverage of intravenous therapy and medications was required for '94 per the '93 Call Letter. This benefit was previously listed under Prescription Drug Benefits.}*** | $10 per visit |

| **Home health services** *(Continued)* | **You pay** |
|---|---|
| *Not covered:*<br>• *nursing care requested by, or for the convenience of, the patient or the patient's family;*<br>• *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.* | *All charges.* |
| **Alternative treatments** | |
| Acupuncture – by a doctor of medicine or osteopathy for: anesthesia, pain relief *{plan specific}* | $10 per visit |
| *Not covered:*<br>• *chiropractic services*<br>• *naturopathic services*<br>• *hypnotherapy*<br>• *biofeedback* | *All charges.* |
| **Educational classes and programs** | |
| Coverage is limited to:<br><br>• Smoking Cessation – Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs.<br><br>• Diabetes self-management<br><br>***{You may list classes or support sessions that promote self-care on this page with other preventive services IF they are included in the community package, and thus are paid for by our premium. Charges, if any, should be minimal. If not under community package, list on non-FEHB page.}*** | $10 per visit |

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

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.
- Plan physicians must provide or arrange your care.
- 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 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. 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 covered 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 and identify which surgeries require precertification. *{Plan specific – delete if not applicable}*

IMPORTANT

| Benefit Description | You pay<br>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, can say "We added asterisks -*- to show when it does not apply. Plan, delete this row if you don't' have a deductible.}* | |
| **Surgical procedures** | |
| • Treatment of fractures, including casting<br>• Normal pre- and post-operative care by the surgeon<br>• Correction of amblyopia and strabismus<br>• Endoscopy procedure<br>• Biopsy procedure<br>• Removal of tumors and cysts<br>• Correction of congenital anomalies (see reconstructive surgery)<br>• 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 *{Define this way, if you need to define – put your limits, if any, etc}*<br>• Insertion of internal prostethic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. | $10 per visit |

*Surgical procedures continued on next page.*

| **Surgical procedures** *(Continued)* | **You pay** |
|---|---|
| ***{Surgical treatment of morbid obesity is required of Federally-qualified plans, and therefore FEHB HMOs. In our view, surgery for morbid obesity should be performed only as a last resort, when the member's health is endangered and more conservative medical measures, including prescription drugs such as appetite suppressants, have not been successful.}***<br><br>***{The internal prosthetic device must be medically necessary to restore bodily function and require a surgical incision (as opposed to an external prosthetic device). Examples: artificial knuckles and joints, pacemakers, insulin pump, defibrillator, penile implants. Medically necessary implants are required of Federally-qualified HMOs, and therefore FEHB HMOs. The Plan may exclude the cost of the device if it is excluded from their community package but must cover the surgery. List non-covered devices under Not covered.}*** | |
| • Voluntary sterilization<br>• Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a).<br>• Treatment of burns<br><br>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. | $10 per visit |
| *Not covered:*<br>• *Reversal of voluntary sterilization*<br>• *Routine treatment of conditions of the foot; see Foot care.* | *All charges.* |
| **Reconstructive surgery** | |
| ***{You may not limited this benefit as to time or cost; nor apply a deductible, or coinsurance in excess of 50%. When this language was mandated in 1992 for all FEHB plans, in conjunction with the plastic surgery exclusion, it was our intent to avoid lists of specific procedures to be covered or excluded. We expect reconstructive surgery following a mastectomy to approximate a normal appearance, including reconstruction of the nipple area; surgery would include distant tissue transfers and reconstruction of the healthy breast when necessary to restore symmetry.}***<br>• Surgery to correct a functional defect<br>• Surgery to correct a condition caused by injury or illness if:<br>  •• the condition produced a major effect on the member's appearance and<br>  •• the condition can reasonably be expected to be corrected by such surgery<br>• 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; webbed fingers; and webbed toes. | $10 per visit |

| **Reconstructive surgery** *(Continued)* | **You pay** |
|---|---|
| • All stages of breast reconstruction surgery following a mastectomy, such as:<br>•• surgery to produce a symmetrical appearance on the other breast;<br>•• treatment of any physical complications, such as lymphedemas;<br>•• breast prostheses and surgical bras and replacements (see Prosthetic devices)<br>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. {***This requirement is effective 1/1/98, per the 3/31/97 Call Letter.}*** | See above. |
| *Not covered:*<br>• *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*<br>• *Surgeries related to sex transformation*<br>***{You may <u>not</u> exclude sexual inadequacy and sexual dysfunction. Coverage for both are required of federally qualified plans, and therefore required of HMOs in the FEHB.}*** | *All charges* |
| **Oral and maxillofacial surgery** | |
| Oral surgical procedures, limited to:<br>• Reduction of fractures of the jaws or facial bones;<br>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;<br>• Removal of stones from salivary ducts;<br>• Excision of leukoplakia or malignancies;<br>• Excision of cysts and incision of abscesses when done as independent procedures; and<br>• Other surgical procedures that do not involve the teeth or their supporting structures.<br>***{Our intention is that this surgery is performed only when medically necessary; for example, orthognathic surgery would be covered when the member's health is affected but not when the doctor determines it is to improve the appearance of a functioning structure.}*** | $10 per visit |
| *Not covered:*<br>• *Oral implants and transplants*<br>• *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*<br>***{Treatment of TMJ, including surgical and non-surgical intervention, corrective orthopedic appliances and physical therapy, is required the same as for any other skeletal joint and may not be excluded; related dental work may be excluded or limited.}*** | *All charges.* |

| Organ/tissue transplants | You pay |
|---|---|
| Limited to:<br>• Cornea<br>• Heart<br>• Heart/lung<br>• Kidney<br>• Kidney/Pancreas<br>• Liver<br>• Lung: Single –Double<br>• Pancreas<br>• Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors<br>• National Transplant Program (NTP) - ……*{plan specific here}*<br>Limited Benefits - 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.<br>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. ***{You may require coinsurance for donor expenses of up to 20% of charges. The language "when we cover the recipient " is intended to prevent someone donating an organ to a non-Plan member from seeking coverage for the operation.}***<br>***{We require full coverage of cornea, heart, kidney and liver transplants. You may cover additional transplants, such as lung (single/double), heart/lung, pancreas, pancreas/kidney. Leading the covered list with "Limited to" and the optional exclusion of "Transplants not listed as covered", under Not covered, clarifies that you do not cover other non-experimental transplants. You may limit coverage of autologous bone marrow transplants to non-random clinical trials, and propose limitations such as specific treatment location, requirement of medical director approval, etc.}*** | $10 per visit |
| *Not covered:*<br>• *Donor screening tests and donor search expenses, except those performed for the actual donor*<br>• *Implants of artificial organs*<br>• *Transplants not listed as covered*<br>***{You may not specify the type of breast cancer covered or not covered, e.g., stage 2. This does not mean that you must pay for a stage 4 case but rather that you must determine if stage 4 is medically necessary treatment and communicate that reason to the patient.}*** | *All charges* |

| Anesthesia | You pay |
|---|---|
| Professional services provided in –<br>• Hospital (inpatient) | $10 per visit |
| Professional services provided in –<br>• Hospital outpatient department<br>• Skilled nursing facility<br>• Ambulatory surgical center<br>• Office | $10 per visit |

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

IMPORTANT

**Here are some important things to remember about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- 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)". ***{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. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification. *{Don't add this bullet unless you have precertification.--You probably DON'T have precertification.}*

IMPORTANT

| Benefit Description | You pay |
|---|---|
| **NOTE: The calendar year deductible applies only when we say below: "calendar year deductible applies".** *{If you don't have a calendar year deductible, delete this whole row.}* | |
| **Inpatient hospital** | |
| Room and board, such as<br>• ward, semiprivate, or intensive care accommodations;<br>• general nursing care; and<br>• meals and special diets.<br><br>NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.<br><br>***{"Special duty nursing when medically necessary" and private rooms when "medically necessary during inpatient hospitalization" are basic services required of Federally-qualified HMOs without time or cost limitations, and thus required of FEHB plans as well.}*** | Nothing<br><br>*{If you have an inpatient copayment, say:*<br><br>$100 per admission<br><br>*{Throughout this sample table, we've shown "Nothing"}*<br><br>***{We prefer Plan hospital copays not to exceed $100 per admission. As we view hospital care as a basic benefit, coinsurance is not acceptable. Copays count toward annual out-of-pocket maximum.}*** |

*Inpatient hospital continued on next page.*

| **Inpatient hospital** *(Continued)* | **You pay** |
|---|---|
| Other hospital services and supplies, such as:<br>• Operating, recovery, maternity, and other treatment rooms<br>• Prescribed drugs and medicines<br>• Diagnostic laboratory tests and X-rays<br>• Administration of blood and blood products<br>• Blood or blood plasma, if not donated or replaced<br>• Dressings, splints, casts, and sterile tray services<br>• Medical supplies and equipment, including oxygen<br>• Anesthetics, including nurse anesthetist services<br>• Take-home items<br>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)<br><br>***{In-hospital administration of blood and blood products (including "blood processing") is required of Federally-qualified plans and of FEHB HMOs. You may exclude the coverage of blood that is not donated or replaced if this is a community exclusion}.*** | Nothing |
| *Not covered:*<br>• *Custodial care*<br>• *Non-covered facilities, such as nursing homes, extended care facilities, schools*<br>• *Personal comfort items, such as telephone, television, barber services, guest meals and beds*<br>• *Private nursing care* | *All charges.* |
| **Outpatient hospital or ambulatory surgical center** | |
| • Operating, recovery, and other treatment rooms<br>• Prescribed drugs and medicines<br>• Diagnostic laboratory tests, X-rays, and pathology services<br>• Administration of blood, blood plasma, and other biologicals<br>• Blood and blood plasma, if not donated or replaced<br>• Pre-surgical testing<br>• Dressings, casts, and sterile tray services<br>• Medical supplies, including oxygen<br>• Anesthetics and anesthesia service<br><br>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. | Nothing |
| *Not covered: blood and blood derivatives not replaced by the member* | *All charges* |

| Extended care benefits/skilled nursing care facility benefits | You pay |
|---|---|
| Extended care benefit: *{Insert benefit; day limits, etc}*<br><br>*{Extended care is to be used in addition to hospital care, not in place of hospital care. You must provide a minimum of 30 days of extended care coverage per year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate. As it is considered to be a basic benefit, coinsurance may not be applied. We prefer to state covered days "per calendar year", not "per confinement" or "per condition." Any copays count toward annual out-of-pocket maximum}*<br><br>*{If you cover care in a sub-acute facility you may describe it here.}* | Nothing<br>. |
| Skilled nursing facility (SNF): {*Insert benefit; day limits, etc. }* | Nothing |
| *(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** | |
| *{Insert benefit}*<br><br>***{Hospice care is an optional benefit we strongly encourage for FEHB HMOs. Adjust language to reflect Plan benefit.}*** | Nothing |
| *Not covered: Independent nursing, homemaker services* | *All charges* |
| **Ambulance** | |
| • Local professional ambulance service when medically appropriate | Nothing |

## 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."}}. {{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. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

### What is a medical emergency?

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

### What to do in case of emergency:

{Insert instructions -- show your emergency and urgent care procedures; numbers to call, etc. Distinguish between in-area and out of area, if there's a difference.}

**Emergencies within our service area:** *{Describe}*

**Emergencies outside our service area:** *{Describe}*

***{PLAN -- note:***

***A Federally-qualified plan is required to provide "Instructions to its members on procedures to be followed to secure medically necessary emergency health services both in the service area and out of the service area";***

***{Describe your own procedures, for review by the contract specialist.;***

***{We would not accept a 48-hour reporting requirement as we have no way to enforce it. We prefer to place the responsibility on the member to comply. Thus, if you say "You or a family member must notify the Plan..." you must also include "unless it was not reasonably possible to do so.";***

*{Specify the Plan's requirement for follow-up care after an emergency treated by a non-Plan doctor;*

***{Reflect Plan payment levels and benefits. Plan may reference other facilities, e.g., doctor's office, for which it pays emergency benefits;***

***{A waiver of the copay if admitted is optional but encouraged; and***

***{We will not accept any language that permits retroactive reviews of claims for emergency care.}}***

**~~What is an accidental injury?~~** *{Stet this IF you have a special benefit for 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 |
|---|---|
| **Emergency within our service area** | |
| • Emergency care at a doctor's office<br>• Emergency care at an urgent care center<br>Emergency care as an outpatient or inpatient at a hospital, including doctors' services | $xx per… |
| *Not covered: Elective care or non-emergency care* | *All charges.* |
| **Emergency outside our service area** | |
| • Emergency care at a doctor's office<br>• Emergency care at an urgent care center<br>• Emergency care as an outpatient or inpatient at a hospital, including doctors' services | $xx… |
| *Not covered:*<br>• *Elective care or non-emergency care*<br>• *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*<br>• *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area {If you **cover full-term deliveries outside the service area delete this exclusion}*** | *All charges.* |
| **~~Accidental injury~~** *{{this is primarily a FFS benefit – if you don't have special benefit for accidents, don't add}}* | |
| | |
| **Ambulance** | |
| Professional ambulance service when medically appropriate.<br>See 5(c) for non-emergency service. | $xx per… |
| *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 all 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 your 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. 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.<br><br>For example, this can include:<br><br>• services by providers such as psychiatrists, psychologists, or clinical social workers,<br><br>• any diagnostic test that they order,<br><br>• any facilities that they admit you to, or<br><br>• any drugs that are prescribe for your condition.<br><br>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.<br><br>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.<br><br>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.*

## Network Benefit -- *CONTINUED*

**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 Plan specific 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 Plan 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 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. 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** | |
| *{Plan specific -- add your year 2000 mental health and substance abuse benefits.)*<br><br>***{Acute inpatient detoxification is required of Federally-qualified HMOs, as follows: "Diagnosis and medical treatment for the abuse of or addiction to alcohol and drugs shall include detoxification for alcoholism or drug abuse on either an outpatient or inpatient basis, whichever is medically determined to be appropriate, in addition to the other required basic health services for the treatment of other medical conditions;"}*** | *(insert year 2000 cost sharing)* |
| *Not covered out-of-network: {Insert Plan specific 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 Plan's 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. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **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 the next page.*

| Benefit Description | You pay<br>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.** *{{Delete the row if you don't' have a deductible.}}.* | |
| **Covered medications and supplies** | |
| We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:<br>• *Plan specific – based on what a plan lists in 2000 under "what is covered"*<br>• Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. *{if state law, edit to show}*<br>• Insulin<br>• Disposable needles and syringes for the administration of covered medications<br>• Drugs for sexual dysfunction (see Prior authorization below)<br>• Contraceptive drugs and devices<br><br>***{Insulin is a required benefit.}***<br><br>***{Diabetic supplies other than needles and syringes are not mandated under the FEHB but their coverage is encouraged as preventive services. Plan should include only items it covers and add any not on our list. If Plan covers glucose monitors as durable medical equipment, show under the DME section.}***<br><br>***{Disposable needles and syringes needed to inject covered prescribed medication is a required benefit}***<br><br>***{You must cover the full range of FDA approved prescriptions and devices for birth control.}***<br><br>***{Appetite suppressants may be excluded under the cosmetic purposes exclusion or covered as medically necessary in cases of morbid obesity.}***<br><br>***{You must cover "off-label" use of covered medication if prescribed for such use by a Plan doctor; you may <u>not</u> exclude "drugs used 'off-label'".}***<br><br>***{Prescription benefits provided for other than the usual copay(s) or that are limited as to number of months' supply (e.g., nicotine patches) may be listed here. Sexual dysfunction drug coverage.}*** | $ per….<br>$ per…<br><br>Note: If there is no generic equivalent available, you will still have to pay the brand name copay. *{Insert this if this is the case}*<br><br>***{Lifetime or annual benefit maximums on prescription drugs are not permitted. Drug benefit deductibles may not exceed $600 and member coinsurance may not exceed 50%.}*** |

| **Covered medications and supplies** *(continued)* | **You pay** |
|---|---|
| Here are some things to keep in mind about our prescription drug program:<br><br>• 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.<br><br>• 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 xxxx.<br><br>***{Adjust text to reflect amounts provided per copay, differences in the Plan's copay structure, and/or the plan's policy concerning generic vs. name brand drugs.}***<br><br>***{No revisions will be accepted that involve members in an authorization process or that impose financial consequences on members when primary doctors fail to obtain authorizations}*** | |
| *Not covered:*<br><br>• *Drugs and supplies for cosmetic purposes*<br><br>• *Vitamins, nutrients and food supplements even if a physician prescribes or administers them*<br><br>• *Nonprescription medicines*<br><br>***{It is our policy not to list specific substances (e.g., Rogaine) as excluded, but rather to exclude a class of such substances, e.g., drugs for cosmetic purposes. Among classes of drugs you may <u>not</u> exclude are injectable drugs}*** | *All Charges* |

***{{Plan specific -- put here items that aren't elsewhere -- that are nonetheless important features of your plan. All here are examples only.}}***

## Section 5 (g). Special Features

| Feature | Description |
|---|---|
| **Flexible benefits option** | Under the flexible benefits option, we determine the most effective way to provide services.<br>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.<br>• Alternative benefits are subject to our ongoing review.<br>• By approving an alternative benefit, we cannot guarantee you will get it in the future.<br>• The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.<br>• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.<br>***{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.
- Plan dentists must provide or arrange your care.
- 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.}*
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below. ***{Hospitalization for dental procedures is optional, but strongly recommended to reduce risk of emergency hospitalizations.}***
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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 _____

***{We will purchase this benefit whether or not you have any other dental benefits if it is part of your community package. It always appears under Dental care in FEHB brochures although it is not a dental benefit. This language may be modified to reflect your benefit, e.g., your definition of prompt. It may not include a preexisting condition limitation, such as limiting the benefit to persons who were injured while enrolled in an FEHB plan}***

### Dental benefits

We have no other dental benefits.

***{You may add dental benefits, or may offer dental benefits if you are a plan new to the Program, only when the dental benefits are integral to your community package and sold to all plan members; we will not purchase dental benefits offered as an optional rider or accept a dental benefit offered "free" to the Federal group. Nor will we agree to increases in existing dental coverage.}***

## *{{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** |
| | **High Option** | **Standard Option** | |
| *{List covered services}* | $___ 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} | $xxx |

## Section 5 (i). Point of service benefits

*Plan -- If none, remove this section and renumber next section.*

***If your plan offers a POS product place it here. Work with your contract specialist to have text in plain language and to reflect plan specific benefits. Be sure to add any bullets from Section 5 IMPORTANT headers that apply.***

***Be sure to add any of the IMPORTANT bullets that apply to these benefits.***

Point of Service (POS) Benefits

Facts about this Plan's POS option

At your option, you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care, except for the benefits listed below under "What is not covered." Benefits not covered under Point of Service must either be received from or arranged by Plan doctors to be covered. When you obtain covered non-emergency medical treatment from a non-Plan doctor without a referral from a Plan doctor, you are subject to the deductibles, coinsurance and maximum benefit stated below.

What is covered

***List the medical services that are included in the POS benefit.***

***State which providers' services are subject to POS payment levels and which are subject to in-Plan payment levels. For example, once a non-Plan doctor is engaged, are all charges related to that doctor's services paid at POS levels? Or is the participating hospital this doctor may use paid at in-Plan levels, while the assisting doctors at the hospital paid POS? Or are all participating providers paid in-Plan and only the out-of-network doctor paid at the POS level?***

***State whether services must be obtained within the service area to be eligible for coverage under POS.***

***Define precertification. State the Plan's requirements for precertification. Must the member obtain authorization for the service from a Plan doctor and then seek a non-Plan doctor, or may the member go to a non-Plan doctor to begin with? Also state the penalty for not obtaining precertification. We do not accept a precertification penalty of more than $500.***

***Define deductible. State the Plan's deductible for POS benefits or state that there is no deductible. Mention any family limit.***

***Define coinsurance. State the Plan's coinsurance for POS benefits. OPM prefers 70%/30% but 80%/20% is acceptable. A Plan payment of less than 70% is not acceptable. Plan may use a fee schedule but we prefer the use of UCR. Both the fee schedule and the UCR should be at the 90th percentile of HIAA UCR, or comparable, guidelines. State that the fee schedule or the UCR allowance is set at the 90th percentile of the standard UCR allowance. State that the member will be liable for the member's coinsurance percentage plus any charges in excess of the UCR allowance.***

***State here any limitation or cap on POS benefits, e.g., $1,000,000 per member's lifetime. If applicable, state a catastrophic limit on member's out-of-pocket POS expenses per calendar year. State whether the member's out-of-pocket expenses under POS qualify for the Plan's in-Plan out-of-pocket maximum.***

***State the benefit when a non-participating hospital is used. Clarify whether the Plan will pay a participating hospital in full even though the POS benefit (and non-Plan doctor) are being used. State that the hospital charge, sometimes called facility charge, does not cover any charges for doctors' services.***

***State that true emergency care is always payable as an in-Plan benefit.***

***List any other negotiated language for any other specified benefits such as mental conditions and substance abuse; add a subhead for each.***

***List here all medical services and procedures that are not covered under the POS benefit.***

***Describe how to access POS benefits: what address to use and/or phone number to call. State what information the Plan will need from the member, such as CPT code, date of service, name of doctor or hospital, and member's I.D. number.***

Precertification

Deductible

Coinsurance

Maximum benefit

Hospital/extended care

Emergency benefits

Other benefits

What is not covered

How to obtain benefits

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

***{Optional page, limited to one page only. On this page the Plan may present health-related benefits that we do not buy but that the Plan wishes to offer directly to enrollees, generally at an additional cost. The following entire paragraph is mandatory for plans that use this page.}***

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

{{Plan specific list }}

***{Benefits described on this page must be health-related. They may include dental and vision benefits that we do not purchase and plan wellness or preventive care not included in the community package that the plan offers to its members at little or no charge, such as discounts at fitness clubs, health assessments, maternity counseling and classes in self care for diabetics.}***

***{Language may be included by plans offering Medicare prepaid plans that wish to encourage Federal annuitants to enroll. Plans with Medicare plans are encouraged but not required to advertise them here; in some cases the Medicare plan offers lesser benefits than the Plan's FEHB package.}***