

## Attachment E: Federal Employees Health Benefits—Plain Language

1. Before examples
2. After examples

Attachment E: Federal Employees Health Benefits—Plain Language

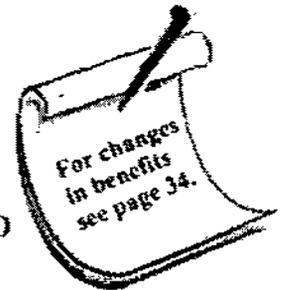
1. Before examples



# NALC Health Benefit Plan

1999

**A Managed Fee-for-Service Plan  
with a Preferred Provider Organization**



**Sponsored and administered by: the National Association of Letter Carriers, AFL-CIO**

**Who may enroll in this Plan:** All Federal and Postal Service employees and annuitants who are eligible to enroll in the FEHB Program may become members of this Plan. To enroll, you must be, or must become, a member of the National Association of Letter Carriers.

**To become a member or associate member:** All active Postal Service employees must be dues paying members of an NALC local. Enter the number of your local immediately after the name of this Plan in Item 1 of Part B of your registration form.

If you are a non-postal employee/annuitant you will automatically become an associate member of NALC upon enrollment in the NALC Health Benefit Plan.

Annuitants (retirees) may enroll in this Plan.

**Membership dues:** \$36 per year for an associate membership. New associate members will be billed for annual dues when the Plan receives notice of enrollment. Continuing associate members will be billed by NALC for the annual membership. Active and retired Postal Service employees' membership dues vary by NALC local.

**Enrollment code for this Plan:**

321 Self Only

322 Self and Family

Visit the OPM website at <http://www.opm.gov/insure>,  
and

Visit the NALC Health Benefit Plan website at <http://www.nalc.org/hbp>.

Authorized for distribution by the:



**United States  
Office of  
Personnel  
Management**



RI 71-9

## NALC Health Benefit Plan

The National Association of Letter Carriers has entered into Contract No. CS 1067 with the Office of Personnel Management (OPM) to provide a health benefits plan (Plan) authorized by the Federal Employees Health Benefits (FEHB) law. The FEHB contract specifies the manner in which it may be modified or terminated.

This brochure is the official statement of benefits on which you can rely. It describes the benefits, exclusions, limitations, and maximums of the NALC Health Benefit Plan for 1999 until amended by future benefit negotiations between OPM and the Carrier. It also describes procedures for obtaining benefits. You should use this brochure to determine your entitlement to benefits. Oral statements cannot modify the benefits described in this brochure.

An enrollee does not have a vested right to receive the benefits in this brochure in 2000 or later years, and does not have a right to benefits available prior to 1999 unless those benefits are contained in this brochure.

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## Inspector General Advisory: Stop Health Care Fraud!

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

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

- Call the provider (doctor, hospital, etc.) and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Carrier at 1-800/433-NALC and explain the situation.
- If the matter is not resolved after speaking to your Carrier (and you still suspect fraud has been committed), call or write:

**THE HEALTH CARE FRAUD HOTLINE**  
202/418-3300

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

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

When you need help with Plan benefits, or getting your ID card, call your Plan at 703/729-4677. The Fraud Hotline cannot help you with these.

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## Using This Brochure

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

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

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

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

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## How This Plan Works

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### Help Contain Costs

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#### You can help

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

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

#### Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with your Plan before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by \$500. Be a responsible consumer. Be aware of your Plan's cost containment provisions. You can avoid penalties and help keep premiums under control by following the procedures specified on pages 23-24 of this brochure.

#### Flexible benefits option

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

#### PPO

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

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### Facilities and Other Providers

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#### Covered facilities

##### Birth center

A free-standing facility that provides comprehensive maternity care in a home-like atmosphere and is licensed or certified by the jurisdiction.

##### Hospice

A facility that: 1) provides care to the terminally ill; 2) is licensed/certified by the jurisdiction in which it operates; 3) is supervised by a staff of doctors (M.D. or D.O.) with at least one such doctor on call 24 hours a day; 4) provides 24-hour-a-day nursing services under the direction of a registered nurse (R.N.) and has a full-time administrator; and 5) provides an ongoing quality assurance program.

##### Hospital

An institution that 1) is accredited as a hospital under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations; or 2) any other institution that is licensed as a hospital, under the supervision of a staff of doctors and with 24-hour-a-day registered nursing service, and that is primarily engaged in providing general inpatient acute care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control.

In no event shall the term "hospital" include a convalescent home or extended care facility, or any institution or part thereof which a) is used principally as a convalescent facility, nursing home, or facility for the aged; b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or c) is operated as a school or residential treatment facility.

##### Skilled nursing facility (SNF)

A facility licensed or certified by the State or eligible for payment under Medicare that provides continuous non-custodial inpatient skilled nursing care by an organized medical staff for post-hospital patients.

##### Treatment facility

A freestanding institution separately licensed by the jurisdiction for rehabilitative treatment of alcoholism or drug abuse on its premises 24 hours a day and that maintains a course of treatment based on the patient's individual needs.

#### Covered providers

For purposes of this Plan, covered providers include:

- 1) A licensed doctor of medicine (M.D.) or osteopathy (D.O.); or, for specified services covered by the Plan, a licensed dentist (D.D.S. or D.M.D.), or podiatrist (D.P.M.), practicing within the scope of their license.

## Facilities and Other Providers *continued*

- 2) A nurse anesthetist (CRNA).
- 3) A community mental health organization: A nonprofit organization or agency with a governing or advisory board representative of the community that provides comprehensive, consultative and emergency services for treatment of mental conditions.
- 4) Other providers listed with the benefits sections.
- 5) Other covered providers include a qualified clinical psychologist, clinical social worker, optometrist, nurse midwife, nurse practitioner/clinical specialist, and nursing school administered clinic. For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

### Coverage in medically underserved areas

Within States designated as medically underserved areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of that license. For 1999, the States designated as medically underserved are: Alabama, Idaho, Louisiana, Mississippi, New Mexico, North Dakota, South Carolina, South Dakota and Wyoming.

### PPO arrangements

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

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

PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. The availability of every speciality in all areas cannot be guaranteed. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply.

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

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

### This Plan's PPO

The Plan offers you a broad, national PPO network. If you choose a PPO provider, then you will be eligible for the enhanced PPO benefit levels described below. Please understand that PPO providers may not be available in all geographic regions, particularly in Maine and Maryland due to state laws affecting provider contracting (Maryland has no hospital network and Maine has no hospital network and no physician/outpatient care network). Information on PPO providers in specific regions is available through the Plan's toll free provider locator service (1-800-622-6252), website ([www.firsthealth.com/MainMenu.htm?Polnum=NAL](http://www.firsthealth.com/MainMenu.htm?Polnum=NAL)), or PPO directories. In areas where a PPO provider is unavailable, members can choose a non-PPO provider and receive standard non-PPO benefits under the Plan.

When a PPO hospital is used, the \$100 per admission deductible and the 20% coinsurance are waived for medical, surgical and maternity confinements (other hospital charges are covered at 100%) and the per admission deductible for mental conditions confinements is \$400. For PPO doctors' outpatient office visits, the Plan pays 100% of the negotiated rate after a \$15 copayment per visit. All other services by PPO doctors and health care professionals are paid at 80% of the negotiated rate under Other Medical Benefits after satisfaction of the \$275 calendar year deductible.

When admitted to a PPO network hospital, show your NALC identification card to the admissions department and advise them that NALC participates in the PPO program. Also make an assignment of benefits to the hospital. The hospital will then file the claim on your behalf. Benefits will be paid to the hospital. **Enrollees residing in a PPO region will receive a listing of the PPO hospitals and health care institutions in their service area.** Contact the Plan at 1-800/548-8454 for information or to obtain a list of PPO hospitals in your area.

Follow the same procedures when visiting a PPO doctor. The doctor and other health care professional networks are generally in the same geographic areas as the hospitals. For information on general practitioners and specialists in those areas, call 1-800/622-6252. The Plan is solely responsible for the selection of PPO providers and any questions regarding PPO providers should be directed to the Plan. When you phone for an appointment, please remember to verify that the physician is still a PPO provider.

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## Cost Sharing

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### Deductibles

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

#### Calendar year

The calendar year deductible is the amount of covered expenses an individual must incur each calendar year before the Plan pays certain benefits. The separate calendar year deductibles apply as follows: Other Medical Benefits – \$275; Inpatient services under Substance Abuse Benefits – \$250; and inpatient and outpatient professional services under Mental Conditions/Substance Abuse Benefits – \$250; and Retail pharmacy – \$25.

Each of these deductibles applies to each individual once during a calendar year regardless of how many illnesses, or injuries the person may have. Only those expenses covered under each provision may be applied toward that deductible. Charges in excess of the reasonable and customary fee, incurred while not enrolled in this Plan, or considered under other benefit provisions (unless specifically listed) do not count toward the deductibles.

#### Hospital admission

There is a \$100 deductible per inpatient hospital medical, surgical, or maternity admission and a \$500 deductible per inpatient mental conditions admission. However, if a PPO hospital is used, the medical per admission deductible is waived, and the deductible for inpatient mental conditions admissions is \$400 (see page 15).

#### Carryover

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

#### Family limit

Under family enrollment, the Other Medical Benefits deductible and the retail pharmacy deductible are considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the deductible reach \$550 (Other Medical Benefits) and \$50 (retail pharmacy) in a calendar year.

### Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductible. The Plan will base this percentage on either the billed charge or the usual, reasonable and customary charge, whichever is less. For instance, under Other Medical Benefits, when the Plan pays 70% of reasonable and customary charges for a covered service, you are responsible for 30% of the reasonable and customary charges, i.e., the coinsurance. In addition, you may be responsible for any excess charge over the Plan's reasonable and customary allowance. For example, if the provider ordinarily charges \$100 for a service but the Plan's reasonable and customary allowance is \$95, the Plan will pay 70% of the allowance (\$66.50). You must pay the 30% coinsurance (\$28.50), plus the difference between the actual charge and the reasonable and customary allowance (\$5), for a total member responsibility of \$33.50. Remember, under Other Medical Benefits, services and supplies by a PPO provider will be payable at 80% of negotiated rates, and if surgery is performed by a PPO doctor, benefits are payable at 85% of negotiated rates, not 70% as for non-PPO doctors.

#### When hospital charges are limited by law

When inpatient claims are paid according to a Diagnostic Related Group (DRG) limit (for instance, for admissions of certain retirees who do not have Medicare - see page 8), the Plan will pay 30% of the total covered amount as room and board charges and 70% as other charges and will apply your coinsurance accordingly.

### Copayments

A copayment is the stated amount the Plan requires you to pay for certain covered services, such as \$12 per prescription for generic mail order drugs or \$15 per office visit at a PPO provider.

#### If provider waives your share

If a provider routinely waives (does not require you to pay) your share of the charge for services rendered, the Plan is not obligated to pay the full percentage of the amount of the provider's original charge it would otherwise have paid. A provider or supplier who routinely waives coinsurance, copayments or deductibles is misstating the actual charge. This practice may be in violation of the law. The Plan will base its percentage on the fee actually charged. For example, if the provider ordinarily charges \$100 for a service but routinely waives the 30% coinsurance, the actual charge is \$70. The Plan will pay \$49 (70% of the actual charge of \$70).

### Lifetime maximums

Substance abuse benefits are limited to a lifetime maximum per person of 30 days room and board and ancillary charges in a treatment facility; Hospice care benefits are limited to a lifetime maximum of \$3,000; and Smoking cessation benefits are limited to a lifetime maximum of \$100.

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## General Limitations

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All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable when determined by the Carrier to be medically necessary. Coverage is provided only for services and supplies that are listed in this brochure. No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under the Plan or be used in the prosecution or defense of a claim under the Plan. This brochure is the official statement of benefits on which you can rely.

### Other sources of benefits

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

#### Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 24-26 apply.

#### Group health insurance and automobile insurance

Coordination of benefits (double coverage) applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Carrier.

When there is double coverage, one plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100% of reasonable and customary charges.

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

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

#### CHAMPUS

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

#### Medicaid

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

#### Workers' compensation

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

#### DVA facilities, DoD facilities, and Indian Health Service

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

#### Other Government agencies

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

#### Liability insurance and third party actions

Subrogation applies when you are sick or injured as a result of the act or omission of another person or party. Subrogation means the Plan's right to recover payments made to you or your dependent by a third party or third party's insurer because of illness or injury caused by a third party. Third party means another person or organization. If you or your covered dependent suffers an injury or illness through the act or omission of another, the Plan requires that it be reimbursed for benefits paid by the Plan in an amount not to exceed the amount of the recovery, or that it be subrogated to your (or your dependent's) rights to the extent of the benefits paid, including the right to bring suit. All recoveries from a third party (whether by lawsuit, settlement or otherwise) must be used to reimburse the Plan for benefits paid. The Plan's share of the recovery will not be reduced because you or your dependent do not receive the full amount of damages claimed, unless the Plan agrees in writing to a reduction.

If you or your dependent are injured because of a third party's action or omission: 1) The Plan will pay benefits for that injury subject to the conditions that you and your dependent: a) do not take any

## General Limitations *continued*

action that would prejudice the Plan's ability to recover benefits; and b) will cooperate in doing what is reasonably necessary to assist the Plan in any recovery. 2) The Plan's right of reimbursement extends only to the amount of Plan benefits paid or to be paid because of the injury. 3) The Plan may insist upon an assignment of the proceeds of the claim or right of action against the third party and may withhold payment of benefits otherwise due until the assignment is provided.

You are required to notify the Plan promptly of any third party claim that you may have for damages for which the Plan has paid or may pay benefits. In addition, you are required to notify the Plan of any recovery, whether in or out of court, that you or your dependent obtain and to reimburse the Plan to the extent of benefits paid by the Plan. Any reduction of the Plan's claim for payment of attorney's fees or costs associated with the claim is subject to prior approval by the Plan. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

### Overpayments

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

### Vested rights

An enrollee does not have a vested right to receive the benefits in this brochure in 2000 or later years, and does not have a right to benefits available prior to 1999 unless those benefits are contained in this brochure.

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

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

#### Inpatient hospital care

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

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan for assistance.

#### Physician services

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

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

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

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

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

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

The Carrier's explanation of benefits (EOB) will tell you how much the physician can charge you in addition to what the Plan paid. If you are billed more than the physician is allowed to charge, ask the physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan for assistance.

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## General Exclusions

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

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

### Benefits will not be paid for services and supplies when:

- No charge would be made if the covered individual had no health insurance coverage
- Furnished without charge (except as described on page 7); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat
- Furnished by immediate relatives or household members, such as spouse, parent, child, brother or sister by blood, marriage or adoption
- Furnished or billed by a provider or facility that has been barred from the FEHB Program
- Furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered
- For or related to sex transformation, sexual dysfunction or sexual inadequacy (except as provided on page 19)
- Not specifically listed as covered or received in connection with a procedure not listed as covered
- Investigational or experimental
- Not provided in accordance with accepted professional medical standards in the United States
- Furnished by practitioners other than those defined as covered providers on pages 4-5
- Obtained while not covered by this Plan

### Benefits will not be paid for:

- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
- Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 8), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge)(see pages 25-26), or State premium taxes however applied.
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.
- Any portion of a fee that the Plan determines to be in excess of the reasonable and customary charge
- Any treatment for cosmetic purposes
- Custodial care as defined on page 29
- Injections of growth hormones and related supplies, except when preauthorization has been obtained through the Plan (see page 17)
- Interest, charges for completion of claim forms or missed or cancelled appointments, or similar administrative charges made by providers
- Nonmedical social services; recreational therapy; educational and training services; and training in activities of daily living
- Nonsurgical treatment for weight reduction or obesity
- Speech therapy, except as provided on page 17
- Testing for mental aptitude or scholastic ability
- Therapy for developmental delays, learning disabilities, stuttering, tongue thrusting or deviate swallowing
- Transportation or travel (other than covered ambulance services and travel under the managed transplant system)
- Standby physicians and surgeons, except during angioplasty or other high risk procedures when the Plan determines standbys are medically necessary
- Dental services and supplies except those oral surgical procedures listed on page 12

# Benefits

## Inpatient Hospital Benefits

<b>What is covered</b>	The Plan pays for inpatient hospital services as shown below.
<b>Precertification</b>	The medical necessity of your hospital admission <b>must</b> be precertified for you to receive full Plan benefits. Emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by \$500. See pages 23-24 for details.
<b>Waiver</b>	This precertification requirement does not apply to persons whose primary coverage is Medicare Part A or another health insurance policy or when the hospital admission is outside the United States and Puerto Rico. For information on when Medicare is primary, see page 25.
<b>Room and board</b>	Plan pays for ward, semiprivate or intensive care accommodations including general nursing care, meals and special diets furnished by a hospital for an inpatient. Charges for a private room will be covered only when the patient's isolation is required by law or the Plan determines that isolation is required to prevent contagion. If for any other reason a private room is used, the Plan will pay the hospital's average charge for semiprivate accommodations. If the hospital has private accommodations only, the average semiprivate rate is determined on the basis of the charges of the most comparable hospital in the area.
<b>PPO benefit</b>	Plan pays room and board at 100% with no deductible when admission is to a PPO hospital. See page 5.
<b>Non-PPO benefit</b>	After a \$100 deductible per admission, Plan pays room and board at 80%. Flat rate hospital charges for non-PPO hospitals are prorated: 30% room and board and 70% other charges. Other prorations may apply to PPO hospitals for which rates are negotiated. (See page 6, <i>When hospital charges are limited by law.</i> )
<b>Other charges</b>	Plan pays for other covered inpatient services and supplies as shown below: <ul style="list-style-type: none"><li>• Professional ambulance service to the nearest hospital equipped to handle the patient's condition</li><li>• Anesthetics and oxygen including nurse anesthetist services</li><li>• X-ray and laboratory tests</li><li>• Blood or blood plasma, if not donated or replaced</li><li>• Internal prostheses, including the first internal breast prosthesis following a mastectomy</li><li>• Drugs and medicines</li><li>• Additional ancillary services such as operating, recovery and treatment rooms, equipment and dressings, splints and casts</li></ul>
<b>PPO benefit</b>	Plan pays Other charges at 100% when admission is to a PPO hospital. See page 5.
<b>Non-PPO benefit</b>	Plan pays Other charges at 80%.
<b>Limited benefits</b>	
<b>Pre-admission testing</b>	Plan pays for pre-admission testing within 7 days of admission or outpatient surgery. Covered screening tests include chest X-rays, electrocardiograms, urinalyses and blood work but do not include diagnostic tests such as magnetic resonance imaging, throat cultures or similar studies.
<b>PPO benefit</b>	Plan pays for pre-admission testing at 100% when provided by a PPO hospital. See page 5.
<b>Non-PPO benefit</b>	Plan pays for pre-admission testing at 80%.
<b>Hospitalization for dental work and foot treatment</b>	Plan pays benefits for hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. Hospital benefits for inpatient foot treatment are payable even if no other benefits are payable.

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## Inpatient Hospital Benefits *continued*

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### Related benefits

#### Professional charges

Doctors' inpatient medical visits are covered under Other Medical Benefits. For inpatient services by anesthesiologists, radiologists and pathologists:

#### PPO benefit

Plan pays 80% of negotiated rate. See page 5.

#### Non-PPO benefit

Plan pays 70% of the reasonable and customary charge.

#### Take-home items

Medical supplies, appliances, medical equipment and any covered items billed by a hospital for use at home are covered only under Other Medical Benefits.

### What is not covered

- Room and board and doctor care when, in the Carrier's judgment, an admission or portion thereof is not medically necessary, i.e., the medical services did not require the acute care setting, but could have been provided in a doctor's office, hospital outpatient department, skilled nursing facility or other setting without adversely affecting the patient's condition or the quality of medical care rendered. In this event, the Carrier will pay benefits for services and supplies other than room and board and in-hospital physician care at the level at which they would have been covered if provided in an alternative setting.
- Room and board in institutions which do not meet the definition of *Covered facilities* on page 4, such as nursing homes, extended care facilities, schools, residential treatment centers, halfway houses or which have as their primary purpose the furnishing of food, shelter, training or non-medical personal services
- Personal comfort items, such as telephone, television, barber services, guest meals and beds
- Surcharges made by hospitals
- Private duty nursing care while confined in a hospital
- Custodial care as defined on page 29

**THE NON-PPO BENEFITS ARE THE STANDARD BENEFITS OF THIS PLAN. PPO BENEFITS APPLY ONLY WHEN YOU USE A PPO PROVIDER. WHEN NO PPO PROVIDER IS AVAILABLE, NON-PPO BENEFITS APPLY.**

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## Surgical Benefits

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### What is covered

The Plan pays for the following services:

#### Hospital inpatient/outpatient

Surgeons' charges, including procedures for sterilization and gastric bypass for morbid obesity.

#### PPO benefit

If the surgery is performed by a Plan PPO network doctor, benefits for the inpatient or outpatient surgical procedure will be payable at 85% of the surgeon's negotiated rate after satisfaction of the \$275 calendar year deductible; see page 6.

#### Non-PPO benefit

If the surgery is not performed by a Plan PPO network doctor, benefits for the inpatient or outpatient surgical procedure will be payable at 70% of the reasonable and customary charge after satisfaction of the \$275 calendar year deductible.

#### Multiple surgical procedures

When multiple or bilateral surgical procedures that add time or complexity to patient care are performed during the same operative session, the Plan will consider as an eligible expense the reasonable and customary charge for the first or major procedure in full plus one-half the value of the second or lesser procedure(s).

#### Incidental procedures

When an incidental procedure (e.g., appendectomy, lysis of adhesion, puncture of ovarian cyst) is performed through the same incision, the benefit shall be that of the major procedure only. Separate benefits will not be provided for procedures deemed by the Plan to be incidental to the total surgery.

#### Assistant surgeon (inpatient/outpatient)

For assistant surgeons' fees, the Plan will consider up to 25% of the reasonable and customary surgical charge as a covered expense.

#### Second opinion (voluntary)

Charges for a second surgical opinion (or a third opinion if the second opinion does not confirm the initial recommendation) are considered under Other Medical Benefits.

## Surgical Benefits *continued*

### Related benefits

#### Professional charges

Inpatient: see Professional charges on page 11.

Outpatient services by anesthesiologists, radiologists and pathologists:

#### PPO benefit

Plan pays 80% of negotiated rate after satisfaction of the \$275 calendar year deductible.

#### Non-PPO benefit

Plan pays 70% of the reasonable and customary charge after satisfaction of the \$275 calendar year deductible.

#### Organ/tissue transplants and donor expenses

##### What is covered

The following human organ/tissue transplant procedures are covered, subject to the conditions and limitations below:

- Bone, cornea, heart, heart/lung, kidney, liver, pancreas, and kidney/pancreas
- Single or double lung transplants, limited to patients for the following end-stage pulmonary diseases: primary fibrosis, primary pulmonary hypertension, or emphysema; double lung transplants, limited to patients with cystic fibrosis.

Bone marrow transplants and stem cell support as follows:

- Allogeneic bone marrow transplants, limited to patients with acute leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, aplastic anemia, chronic myelogenous leukemia, infantile malignant osteoporosis, severe combined immunodeficiency, thalassemia major, or Wiskott-Aldrich syndrome;
- Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support for 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.

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

##### National transplant program

The Plan participates in a National Transplant Program administered by First Health. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor must contact First Health at 1-800/622-6252 and ask to speak to a Transplant Case Manager. You will be provided with information about this program and about transplant preferred providers.

The reasonable and customary charges for services performed by a National Transplant Program provider, whether incurred by the recipient or donor are paid at 100%. Participants in the program must receive prior approval from the Plan for travel and lodging costs.

##### Limited benefits

If prior approval is not obtained or a designated facility is not used, pretransplant evaluation, organ procurement, inpatient hospital, surgical and medical expenses for covered transplants, whether incurred by the recipient or donor, are limited to a maximum of \$100,000 for each listed transplant (kidney limit, \$50,000).

##### What is not covered

- Donor screening tests for organ transplants, except those performed for the actual donor
- Implants of artificial organs
- Transplants not listed as covered

#### Oral and maxillofacial surgery

The following oral surgical procedures are covered:

- 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.

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## **Surgical Benefits** *continued*

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### **Mastectomy surgery**

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

### **What is not covered**

- Oral implants and transplants
- Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)
- Voluntary reversal of surgical sterilization
- Cutting, trimming or removal of corns, calluses or the free edge of toenails, and similar routine treatment of conditions of the foot, except when necessary because the individual is under active treatment for a metabolic or peripheral vascular disease
- Refractive keratoplasty or radial keratotomy
- Cosmetic surgery (see definition on page 29), except for repair of accidental injury if repair is initiated within six months after an accident, to correct a congenital anomaly of a child born under the Program, and for breast reconstruction following a mastectomy
- Standby physicians and surgeons, except during angioplasty or other high risk procedures when the Plan determines standbys are medically necessary.

**THE NON-PPO BENEFITS ARE THE STANDARD BENEFITS OF THIS PLAN. PPO BENEFITS APPLY ONLY WHEN YOU USE A PPO PROVIDER. WHEN NO PPO PROVIDER IS AVAILABLE, NON-PPO BENEFITS APPLY.**

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# Maternity Benefits

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## What is covered

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

### Inpatient hospital Precertification

Precertification is not required for maternity admissions for routine deliveries. However, if your medical condition requires that you stay more than 48 hours after a regular delivery or 96 hours after a cesarean section, you, your physician or the hospital must contact the Plan for certification of the additional days. If the certification for additional days is not obtained and a retrospective medical review determines the additional days were not medically necessary, the Plan will not pay for charges incurred on those noncertified days. If certification is not obtained but the benefits are otherwise payable, benefits for the admission will be reduced by \$500. Newborn confinements that extend beyond the mother's discharge must also be precertified. If any of the above are not done, the benefits payable will be reduced by \$500. See pages 23-24 for details.

### Room and board

Plan pays for ward, semiprivate or intensive care accommodations including general nursing care, meals and special diets furnished by a hospital for an inpatient.

#### PPO benefit

Plan pays room and board at **100%** with no deductible when admission is to a PPO hospital. See page 5.

#### Non-PPO benefit

After a \$100 deductible per admission, Plan pays room and board at **80%**.

Flat rate hospital charges for non-PPO hospitals are prorated: 30% room and board and 70% other charges. Other prorations may apply to PPO hospitals for which rates are negotiated. (See page 6, *When hospital charges are limited by law.*)

### Other charges

Plan pays for other covered hospital services and supplies. See Inpatient Hospital Benefits.

#### PPO benefit

Plan pays Other charges at **100%** when admission is to a PPO hospital. See page 6.

#### Non-PPO benefit

Plan pays Other charges at **80%**.

Ordinary bassinet or nursery charges on days when the mother would normally be confined after delivery are considered hospital expenses of the mother. Other expenses of the child will be considered the child's own and will be payable only if the child is covered under a Self and Family enrollment and if the confinement is for the treatment of illness or injury of the child.

## Outpatient care

The Plan pays the same benefits as listed above for admission to a birthing center.

### Obstetrical care

Plan pays delivery fees (including prenatal and postpartum care), and services of doctors and nurse midwives.

#### PPO benefit

If the delivery is performed by a Plan PPO network provider, the benefit for delivery will be payable at **85%** of the negotiated rate after satisfaction of the \$275 calendar year deductible; see page 6.

#### Non-PPO benefit

If the delivery is performed by a non-PPO provider, the benefit for delivery will be payable at **70%** of the reasonable and customary charge after satisfaction of the \$275 calendar year deductible.

## Related benefits

### Diagnosis and treatment of infertility

Diagnostic testing and treatment of infertility (except as excluded below) are covered under Other Medical Benefits.

### Testing

Group B streptococcus infection screening of pregnant women, sonograms, fetal monitoring, and other related tests medically indicated for the unborn child are covered under Other Medical Benefits. Amniocentesis is covered under Surgical Benefits.

### Voluntary sterilization

See Surgical Benefits.

## For whom

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

## What is not covered

- Routine sonograms to determine fetal age, size or sex
- Assisted Reproductive Technology (ART) procedures such as artificial insemination, in vitro fertilization, embryo transfer and GIFT, as well as services and supplies related to ART procedures are not covered.
- Contraceptive implants and devices
- Genetic counseling

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## Mental Conditions/Substance Abuse Benefits

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### What is covered

#### Mental conditions

##### Inpatient care

The Plan pays for the following services:

Plan pays for ward or semiprivate accommodations and other hospital charges at 50% up to 50 days per calendar year, after the stated deductible.

##### PPO benefit

After satisfaction of a \$400 deductible per admission, Plan pays 50% of charges up to 50 days per calendar year when admission is to a PPO hospital. See page 5.

##### Non-PPO benefit

After satisfaction of a \$500 deductible per admission, Plan pays 50% of charges up to 50 days per calendar year. (See page 6, *When hospital charges are limited by law.*)

##### Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by \$500. See pages 23-24 for details.

##### Inpatient visits and outpatient care

See Professional services below.

##### Catastrophic protection

The Plan pays 100% of covered charges for the remainder of the calendar year, after your coinsurance on out-of-pocket expenses for inpatient mental conditions care total \$8,000, not to exceed the calendar year maximum of 50 days.

#### Substance abuse

##### Inpatient care

After satisfaction of a separate \$250 inpatient Substance Abuse calendar year deductible, room and board and ancillary charges for confinements in a treatment facility for rehabilitative treatment of alcoholism or substance abuse are paid at 50% and are limited to a 30-day lifetime maximum per person. (See page 6, *When hospital charges are limited by law.*)

##### Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by \$500. See pages 23-24 for details.

##### Inpatient visits and outpatient care

See Professional services below.

##### Lifetime maximum

There is a 30-day lifetime maximum per person for inpatient rehabilitative substance abuse care.

#### Mental conditions/ substance abuse

##### Professional services

##### PPO benefit

After satisfaction of a \$250 Mental conditions/Substance abuse calendar year deductible, the Plan pays 60% of charges for inpatient and outpatient services by covered providers for treatment of mental conditions/substance abuse up to a maximum of 30 visits.

##### Non-PPO benefit

After satisfaction of a \$250 Mental conditions/Substance abuse calendar year deductible, the Plan pays 50% of charges for inpatient and outpatient services by covered providers for treatment of mental conditions/substance abuse up to a maximum of 30 visits.

### What is not covered

- Services by pastoral, marital, drug/alcohol and other counselors
- Treatment for learning disabilities and mental retardation
- Treatment for marital discord
- Services rendered or billed by schools, residential treatment centers or halfway houses or members of their staffs
- Room and board and doctor care when, in the Carrier's judgement, an admission or portion thereof, is not medically necessary, i.e., the medical services did not require the acute care setting, but could have been provided in a doctor's office, hospital outpatient department, or some other setting without adversely affecting the patient's condition or the quality of care rendered.

**THE NON-PPO BENEFITS ARE THE STANDARD BENEFITS OF THIS PLAN. PPO BENEFITS APPLY ONLY WHEN YOU USE A PPO PROVIDER. WHEN NO PPO PROVIDER IS AVAILABLE, NON-PPO BENEFITS APPLY.**

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## Other Medical Benefits

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### What is covered

#### Outpatient office visits

Benefits for visits to a doctor's office are covered as follows:

##### PPO benefit

After you pay a \$15 copayment for each covered outpatient office visit with a PPO provider (see page 5), the Plan pays 100% of the negotiated rate. The \$275 calendar year deductible does not apply to this benefit. Home and hospital visits, consultations and second opinions are covered under Other services below.

##### Non-PPO benefit

After the \$275 calendar year deductible has been met, the Plan pays 70% of reasonable and customary charges for covered outpatient office visits provided by a non-PPO provider.

#### Other services

##### PPO benefit

After the \$275 calendar year deductible has been met, the Plan pays 80% of the negotiated rate for the following services and supplies provided by a Plan PPO network provider. See page 5.

##### Non-PPO benefit

After the \$275 calendar year deductible has been met, the Plan pays 70% of reasonable and customary charges for the following services and supplies provided by a non-PPO provider.

- Doctors' nonsurgical services for home and hospital visits, medical consultations and second surgical opinions, except surgical follow-up care covered under Surgical Benefits
- Initial examination of a newborn child covered under a Self and Family enrollment
- Acupuncture by a doctor of medicine or osteopathy

Services and supplies outside a hospital (or as a hospital outpatient) prescribed by the attending doctor, as follows:

- Insulin and diabetic supplies (also see *Prescription Drug Benefits*, page 18)
- Allergy tests and treatments, including injectable antigens
- Needles and syringes for covered injectables and ostomy and catheter supplies
- Home IV and antibiotic therapy
- Local professional ambulance service when medically appropriate
- Anesthetics and their administration
- Oxygen
- Hemodialysis and peritoneal dialysis
- Artificial limbs and eyes; stump hose
- Chemo- and radiation therapy; high dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 12
- Blood and blood plasma, if not donated or replaced
- Specially made durable leg, arm, neck and back braces
- Diagnostic X-rays, laboratory tests and pathology services
- Outpatient hospital charges related to dental procedures only when necessitated by a non-dental physical impairment
- First externally worn breast prosthesis immediately following a mastectomy
- One pair of eyeglasses or contact lenses if required to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)
- First hearing aid and testing only when necessitated by accidental injury

#### Durable medical equipment (DME)

##### What is covered

- Rental or purchase, at the Plan's option, including repair and adjustment, of oxygen apparatus, dialysis appliances and similar durable medical equipment. Also included are hospital beds, wheelchairs, crutches and walkers. Notify the Plan immediately at 1-800/433-NALC when durable medical equipment has been prescribed and the anticipated purchase price or rental charges of an item exceed \$1,000.

##### What is not covered

- DME replacements provided less than 3 years after the last one for which benefits were paid
- Sun or heat lamps; whirlpool baths, saunas and similar household equipment; safety, convenience and exercise equipment; communication equipment including computer "story boards" or "light talkers"; computer switch boards or environmental control units; heating pads; air conditioners, purifiers and humidifiers; stair climbing equipment; stair glides; ramps, elevators and other modifications or alterations to vehicles or households and other items (wigs) that do not meet the definition of durable medical equipment on page 29.

#### Routine services

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

##### Blood lead level screening

Annual coverage of one blood lead level test

## Other Medical Benefits *continued*

<b>Breast cancer screening</b>	Mammograms are covered for women age 35 and older as follows: <ul style="list-style-type: none"><li>• From age 35 through 39, one mammogram screening during this five year period;</li><li>• From age 40 through 64, one mammogram screening every calendar year; and</li><li>• At age 65 and older, one mammogram screening every two consecutive calendar years.</li></ul>
<b>Cervical cancer screening</b>	See Pap smears under Additional Benefits, page 18
<b>Colorectal cancer screening</b>	Annual coverage of one fecal occult blood test for members age 40 and older
<b>Prostate cancer screening</b>	Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older
<b>Blood cholesterol screening</b>	Total blood cholesterol test, every three years, between the ages of 19 and 64
<b>Tetanus-diphtheria immunization</b>	Tetanus-diphtheria (Td) booster, every 10 years, between the ages of 19 and over (except as provided for under <i>Childhood immunizations</i> on page 18)
<b>Influenza/Pneumococcal vaccines</b>	Influenza and pneumococcal vaccines, annually, age 65 and over
<b>Strabismus/Amblyopia eye exam</b>	Eye exam for amblyopia and strabismus, once, between the ages of 2 and 6

### Limited benefits

**Growth hormone therapy** Growth hormone therapy (GHT) is covered only when preauthorization is obtained through the Plan. Call 1-800/433-NALC for preauthorization. If no preauthorization is obtained before treatment is begun, GHT services will be covered only from the date that information is submitted to the Plan that establishes the medical necessity for GHT. If the Plan determines that GHT is not medically necessary, the related services and supplies for GHT will not be covered.

### Hospice care

- What is covered**
- The Plan will pay up to \$3,000 per lifetime for inpatient and outpatient services administered as part of a Hospice care program (see Definitions)
- What is not covered**
- Independent nursing, homemaker or bereavement services

### Rehabilitative therapy

The Plan will pay for up to 90 visits per calendar year for the services of each of the following: qualified physical, speech and occupational therapists. Visits to restore an attained bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury will be covered when the following conditions are met: 1) the care is ordered by the attending doctor; 2) the doctor identifies the specific professional skills required by the patient and the medical necessity for skilled services; and 3) the doctor indicates the length of time the services are needed.

### Smoking cessation benefit

After satisfaction of the calendar year deductible, the Plan will pay up to \$100 for enrollment in one smoking cessation program per member per lifetime for all related expenses, including drugs.

### What is not covered

- Orthopedic shoes, foot orthotics, arch supports, elastic stockings, lumbosacral supports, corsets, trusses and other supportive devices
- Injections of silicone, collagens and similar substances and all related charges
- Eyeglasses, hearing aids and examinations for them (except as covered on page 16), orthoptics (visual training) and eye exercises
- Routine physical checkups and related tests, routine eye and hearing examinations, immunizations and well child care (except as listed above or covered under Additional Benefits)
- Treatment of weak, strained or flat feet; of bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)
- Services by chiropractors, except in those states designated as medically underserved areas (see page 5)
- Chelation therapy, except for acute arsenic, gold, lead or mercury poisoning
- Maintenance therapy including cardiac rehabilitation and exercise programs

**THE NON-PPO BENEFITS ARE THE STANDARD BENEFITS OF THIS PLAN. PPO BENEFITS APPLY ONLY WHEN YOU USE A PPO PROVIDER. WHEN NO PPO PROVIDER IS AVAILABLE, NON-PPO BENEFITS APPLY.**

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## Additional Benefits

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### Accidental injury

The Plan will pay **100%** of the PPO negotiated rate or **100%** of reasonable and customary outpatient charges for nonsurgical services and supplies by a doctor, and for related outpatient hospital services, incurred within 48 hours after an accidental injury, for treatment of that injury. Charges incurred after 48 hours will be considered under Other Medical Benefits.

### Childhood immunizations

Childhood immunizations recommended by the American Academy of Pediatrics are covered at **100%** of reasonable and customary charges for dependent children age 3 to 22. The office visit on the day of the immunization is covered under Other Medical Benefits.

### Pap smears

The Plan will pay up to **\$35** per test. Charges in excess of **\$35** and the office visit charge on the same day will be considered under Other Medical Benefits.

### Skilled nursing care

#### What is covered

The Plan pays **80%** of charges up to a maximum payment of **\$75** per day for up to 90 days per calendar year of skilled nursing care at home. Charges of a registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) are covered only when:

- 1) the care is ordered by the attending doctor;
- 2) the doctor identifies the specific professional skills required by the patient and the medical necessity for skilled services; and
- 3) the doctor indicates the length of time the services are needed.

#### What is 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.

### Skilled nursing facility (SNF)

Plan pays for semiprivate room, board, services and supplies in a SNF up to a maximum of 30 days per confinement (except for mental conditions) when: 1) the patient is admitted directly from a precertified hospital confinement of at least 3 consecutive days, 2) admission is for the same condition as the hospital confinement and is under the supervision of a doctor, 3) skilled nursing care is provided by an R.N., L.P.N., or L.V.N., and 4) confinement is medically appropriate. No admission deductible applies.

#### PPO benefit

Plan pays room, board and other charges at **100%** when admission is to a PPO facility; see page 5.

#### Non-PPO benefit

Plan pays room and board at **100%** and other charges at **80%** when admission is to a non-PPO facility.

### Well child care

The Plan pays **100%** of reasonable and customary charges for routine examinations, immunizations and care for each eligible child to age 3. See Other Medical Benefits for the coverage of the initial newborn exam.

**THE NON-PPO BENEFITS ARE THE STANDARD BENEFITS OF THIS PLAN. PPO BENEFITS APPLY ONLY WHEN YOU USE A PPO PROVIDER. WHEN NO PPO PROVIDER IS AVAILABLE, NON-PPO BENEFITS APPLY.**

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## Prescription Drug Benefits

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### What is covered

Each new enrollee will receive a description of the 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 doctor from either a pharmacy or by mail:

- Drugs and medicines (including those for mental conditions and those administered during a non-covered admission or in a non-covered facility and to assist in smoking cessation) that by Federal law of the United States require a doctor's prescription for their purchase, except as excluded below.

A Federally-approved generic equivalent will be dispensed if it is available, unless your doctor specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your doctor has not specified the name brand drug, you will be required to pay the difference in cost between the name brand drug and the generic.

The Plan administers an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your doctor may prescribe a brand drug from a formulary list. This list of brand name drugs is a preferred list of drugs selected to meet patient needs at a lower cost to the Plan. A brochure is available by calling 1-800-933-NALC.

- Insulin
- Needles and syringes for the administration of covered medications

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## Prescription Drug Benefits *continued*

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### What is not covered

- Drugs for sexual dysfunction will only be covered when the dysfunction is caused by medically documented organic disease. The maximum dosage dispensed will be limited by protocols established by the Plan.
- Drugs and supplies for cosmetic purposes
- Vitamins, nutrients and food supplements even if prescribed or administered by a doctor
- Nonprescription medicines

### From a pharmacy

You may purchase prescription drugs either from retail pharmacies that are part of the Plan's CareSelect Pharmacy Network or from non-Network pharmacies.

### Network retail pharmacy

After the \$25 calendar year drug deductible (\$50 per family) and applicable copayment (\$5 generic, \$10 name brand drug) has been met, Plan pays 100% of covered charges. Present your NALC card to the pharmacy with your prescription and pay any applicable deductible and copayment. You may obtain up to a 30-day supply plus one refill for each prescription purchased from a CareSelect Network pharmacy. The CareSelect Network pharmacy files your claim and is reimbursed by the Plan. After one refill, you must obtain a new prescription and submit it to the mail order program. Note: Failure to do so will result in benefits payable at the non-Network retail pharmacy benefit level.

### Non-network retail pharmacy

After the \$25 calendar year drug deductible (\$50 per family) has been met, Plan pays 60% and you pay 40% of covered charges for up to a 30-day supply and unlimited refills. You will need to file a claim for reimbursement.

### By mail

You may order up to a 90-day (21-day minimum) supply of medications for a \$12 copayment for a generic drug, \$25 copayment for a name brand drug, per prescription or refill. No deductible applies. Allow two weeks for delivery. Please note that medications dispensed through the mail order program are subject to the following standards: the professional judgement of the pharmacist, limitations imposed on controlled substances, manufacturer's recommendations, and applicable state law. In most cases, refills cannot be obtained until 75% of the drug has been used. Use the NALC mail order form/patient profile and preaddressed envelope with your first order. Mail these, with your prescription(s) and a check for \$12 per generic or \$25 per name brand for each prescription or refill, to:

NALC Prescription Drug Program  
P.O. Box 380  
Lincolnshire, IL 60069-0380

### Waivers

The following waivers apply if you have Medicare Part B and Medicare is the primary carrier. If you purchase your prescriptions from CareSelect Network retail pharmacies, your deductible will be waived and your copayments will be \$1 per generic and \$2 per name brand drug (see Network retail pharmacy above). If you purchase your prescriptions from non-Network retail pharmacies, however, only your calendar year deductible will be waived. If you order by mail, your copayments will be \$2 per generic and \$4 per name brand drug and no deductible will apply.

### To claim benefits

When you use a non-Network pharmacy or you use a CareSelect Network pharmacy and are unable to use your card, complete the Short-Term Prescription claim form and mail with your prescription receipts to:

NALC Prescription Drug Program  
P.O. Box 686005  
San Antonio, TX 78268-6005

Receipts must specify the prescription number, name of drug, prescribing doctor's name, date, charge and name of drugstore.

### Double coverage

When there is double coverage and the other carrier is primary, use that carrier's drug benefit first and call 1-800/933-NALC to request a Short-Term claim form. After the primary carrier has processed the claim, complete the claim form, attach the drug receipts and the other carrier's Explanation of Benefits form, and mail to:

NALC Prescription Drug Program  
P.O. Box 686005  
San Antonio, TX 78268-6005

### Questions?

If you have any questions about the Program, wish to locate a CareSelect Network retail pharmacy, or need additional claim forms call 1-800/933-NALC (8:30 a.m. - 10:00 p.m. Mon. - Fri.; 9:00 a.m. - 1:00 p.m. Sat., Eastern time).

**THE NON-PPO BENEFITS ARE THE STANDARD BENEFITS OF THIS PLAN. PPO BENEFITS APPLY ONLY WHEN YOU USE A PPO PROVIDER. WHEN NO PPO PROVIDER IS AVAILABLE, NON-PPO BENEFITS APPLY.**

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## How to Claim Benefits

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### Claim forms, identification cards and questions

If you do not receive your identification card(s) within 60 days after the effective date of your enrollment, call the Carrier at 1-800/433-NALC to report the delay. In the meantime, use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services. This is also the number to call for claim forms or advice on filing claims.

If you have a question concerning Plan benefits, contact the Carrier at 703/729-4677 or you may write to the Carrier at 20547 Waverly Court, Ashburn, VA 20149-0001.

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

### How to file claims

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

- Name of patient and relationship to enrollee
- Plan identification number of the enrollee
- Name and address of person or firm providing the service or supply
- Dates that services or supplies were furnished
- Type of each service or supply (CPT/HCPCS Code) and the charge
- Diagnosis (ICD-9 Code)

In addition:

- A copy of the explanation of benefits (EOB) from any primary payer (such as Medicare) must be sent with your claim.
- Bills for private duty nurses must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment, private duty nursing, and physical, occupational and speech therapy require a written statement from the doctor specifying the medical necessity for the service or supply and the length of time needed.
- Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred.

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

After completing a claim form and attaching proper documentation, send all claims except prescription drug claims to: NALC Health Benefit Plan, 20547 Waverly Court, Ashburn, VA 20149-0001. Phone 703/729-4677

See pages 18-19 for instructions on filing prescription drug claims.

Verification of benefits is valid only when provided by the NALC Health Benefit Plan at the above address.

Hospitals may call 1-800/548-8454 for confirmation of benefits.

### Records

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

### Submit claims promptly

The Carrier will not pay benefits for claims submitted more than two years from the date the expense was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. To avoid denial of payment, submit claims on a timely basis. Once benefits have been paid, there is a three year limitation on the reissuance of uncashed checks.

### Direct payment to hospital or provider of care

**Other Medical Benefits** (subject to the deductible) may not ordinarily be assigned but will be paid directly to the enrollee. Use the Claim Form for Unassigned Bills (CF-2) for filing.

**Hospital benefits**—To authorize direct payment to a hospital, present your identification card upon admission and complete the hospital's standard authorization/assignment of benefits form or the NALC Hospital Claim Form (H-1).

**Doctor benefits**—To authorize direct payment to a doctor or surgeon, complete Form HCFA 1500 (Health Insurance Claim Form) available through your provider's office.

### When more information is needed

Reply promptly when the Carrier requests information in connection with a claim. If you do not respond, the Carrier may delay processing or limit the benefits available. The Carrier, its medical staff and/or an independent medical review, determines whether services, supplies and charges meet the coverage requirements of the Carrier (subject to the disputed claims procedure described on page 21). The Carrier is also entitled to obtain medical or other information, including an independent medical examination, that it may in its discretion consider useful to determine if a service or supply is covered.

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## How to Claim Benefits *continued*

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### Confidentiality

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

### Disputed claims review

#### Reconsideration

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

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

#### OPM review

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

You may also ask OPM for a review if the Carrier fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Carrier. In this case, OPM must receive a request for review within 120 days of your request to the Carrier for reconsideration or of the date you were notified that the Carrier needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the Carrier should have paid the denied claim. If the Carrier has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

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

Medical documents received from you or the Carrier during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act. Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 2, P. O. Box 436, Washington, DC 20044.

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## How to Claim Benefits *continued*

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You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Carrier's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before the OPM when it rendered its decision affirming the Carrier's denial of benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

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

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## Protection Against Catastrophic Costs

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### Catastrophic protection

For those services with coinsurance, the Plan pays 100% of reasonable and customary charges for the remainder of the calendar year after covered out-of-pocket expenses under Inpatient Hospital, Surgical, Maternity, Other Medical Benefits and Additional Benefits (Skilled nursing facility only) total \$3,500 per individual or \$3,500 per family. Out-of-pocket expenses for the purposes of this benefit are:

- The 20% you pay under Non-PPO Inpatient Hospital Benefits;
- The 30% (15% PPO) you pay under Surgical Benefits;
- The 30% (20% PPO) you pay under Other Medical Benefits; and
- The 20% you pay under Additional Benefits for care in a skilled nursing facility.

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

- All deductibles
- Expenses incurred under Additional Benefits for skilled nursing care;
- Expenses incurred under Prescription Drug Benefits;
- Expenses in excess of reasonable and customary charges or maximum benefit limitations;
- The \$15 copayment for a PPO doctor's office visit charge;
- Expenses for mental conditions or substance abuse; and
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 10, 14, 15, 24).

### PPO providers

When your eligible out-of-pocket expenses, as discussed above, from using PPO providers exceed \$3,000 per individual or \$3,000 per family, the Plan pays 100% of its covered PPO charges for covered services when you continue to select PPO providers for the remainder of the calendar year. Whether or not you use PPO providers, your share of out-of-pocket expenses will not exceed \$3,500 per individual or \$3,500 per family in a calendar year.

### Mental Conditions Benefit

The Plan pays 100% of covered charges for the remainder of the calendar year, after coinsurance out-of-pocket expenses for inpatient mental conditions care total \$8,000, not to exceed the calendar year maximum of 30 days.

### Carryover

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

## Other Information

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### Information you have a right to know

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All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling the Carrier at 703/729-4677 or you may write the Carrier at 20547 Waverly Court, Ashburn, VA 20149-0001.

Information that must be made available to you includes:

- Disenrollment rates for 1997.
- Compliance with State and Federal licensing or certification requirements and the dates met. If noncompliant, the reason for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

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### Precertification

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#### Precertify before admission

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

To precertify a scheduled admission:

- You, your representative, your doctor, or your hospital must call the Carrier prior to admission. The toll-free number is 1-800/622-6252.
- Provide the following information: enrollee's name and Plan identification number; patient's name, birth date and phone number; reason for hospitalization, proposed treatment or surgery; name of hospital or facility; name and phone number of admitting doctor; and number of planned days of confinement.

A review coordinator will then tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition. Written confirmation of the Carrier's certification decision will be sent to you, your doctor, and the hospital. If the length of stay needs to be extended, follow the procedures below.

#### Need additional days?

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

#### You don't need to certify an admission when:

- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement (see pages 24-26). Precertification is required, however, when Medicare hospital benefits are exhausted prior to using the lifetime reserve days.
- You are confined in a hospital outside the United States and Puerto Rico.
- The discharge for your maternity admission is within 48 hours after a regular (routine) delivery or within 96 hours after a cesarean delivery.

#### Maternity or emergency admissions

When there is an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone 1-800/622-6252 **within two business days following the day of admission**, even if the patient has been discharged from the hospital. Otherwise, inpatient benefits otherwise payable for the admission will be reduced by \$500.

Newborn confinements that extend beyond the mother's discharge date must also be certified. You, your representative, the doctor or hospital must request certification for the newborn's continued confinement within two business days following the mother's discharge.

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## Precertification *continued*

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### Other considerations

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

### If you do not precertify

If precertification is not obtained before admission to the hospital or after 48 hours after a regular (routine) delivery or 96 hours after a cesarean section delivery (or within two business days following the day of a maternity or emergency admission or, in the case of a newborn, the mother's discharge), a medical necessity determination will be made at the time the claim is filed. If the Carrier determines that the hospitalization was not medically necessary, the inpatient hospital benefits will not be paid. However, the medical supplies and services otherwise payable on an outpatient basis will be paid.

If the claim review determines that the admission was medically necessary, any benefits payable according to all of the terms of this brochure will be reduced by \$500 for failing to have the admission precertified.

If the admission is determined to be medically necessary, but part of the length of stay was found not to be medically necessary, inpatient hospital benefits will not be paid for the portion of the confinement that was not medically necessary. However, medical services and supplies otherwise payable on an outpatient basis will be paid.

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## This Plan and Medicare

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### Coordinating benefits

The following information applies only to enrollees and covered family members who are entitled to benefits from both this Plan and Medicare. You must disclose information about Medicare coverage, including your enrollment in a Medicare prepaid plan, to this Carrier; this applies whether or not you file a claim under Medicare. You must also give this Carrier authorization to obtain information about benefits or services denied or paid by Medicare when they request it. It is also important that you inform the Carrier about other coverage you may have as this coverage may affect the primary/secondary status of this Plan and Medicare (see page 7).

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

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

### This Plan is primary if:

- 1) You are age 65 or over, have Medicare Part A (or Parts A and B), and are employed by the Federal Government;
- 2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are employed by the Federal Government;
- 3) The patient (you or a covered family member) is within the first 30 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD) except when Medicare (based on age or disability) was the patient's primary payer on the day before he or she became eligible for Medicare Part A due to ESRD; or
- 4) The patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the Federal Government.

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

### Medicare is primary if:

- 1) You are an annuitant age 65 or over, covered by Medicare Part A (or Parts A and B) and are not employed by the Federal Government;
- 2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are not employed by the Federal Government;
- 3) You are age 65 or over and (a) you are a Federal judge who retired under title 28, U.S.C., (b) you are a Tax Court judge who retired under Section 7447 of title 26, U.S.C., or (c) you are the covered spouse of a retired judge described in (a) or (b);
- 4) You are an annuitant not employed by the Federal Government, and either you or a covered family member (who may or may not be employed by the Federal Government) is under age 65 and eligible for Medicare on the basis of disability;

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## **This Plan and Medicare** *continued*

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- 5) You are enrolled in Part B only, regardless of your employment status;
- 6) You are age 65 or over and employed by the Federal Government in an appointment that excludes similarly appointed nonretired employees from FEHB coverage, and have Medicare Part A (or Parts A and B);
- 7) You are a former Federal employee receiving workers' compensation and the Office of Workers Compensation has determined that you are unable to return to duty;
- 8) The patient (you or a covered family member) has completed the 30-month ESRD coordination period and is still eligible for Medicare due to ESRD; or
- 9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payer status for the patient under rules 1) through 7) above.

### **When Medicare is primary**

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

- **Inpatient Hospital Benefits:** If you are enrolled in Medicare Part A, the Plan will waive the deductible and coinsurance.
- **Surgical Benefits:** If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance.
- **Mental Conditions/Substance Abuse Benefits:** If you are enrolled in Medicare Part A, the Plan waives the inpatient deductible and coinsurance for hospital charges. If you are enrolled in Medicare Part B, the Plan waives the deductible and coinsurance for professional services and confinements in treatment facilities. Benefit limits and the calendar year maximum will not be waived.
- **Other Medical Benefits:** If you are enrolled in Medicare Part B, the Plan waives the deductible, coinsurance, and outpatient office visit copayments. The lifetime maximum for hospice care will not be waived.
- **Additional Benefits:** If you are enrolled in Medicare Part B, the Plan waives the coinsurance for skilled nursing care and the skilled nursing facility coinsurance.
- **Prescription Drug Benefits:** If you are enrolled in Medicare Part B, the Plan waives the deductible required for purchases from a network or non-network retail pharmacy. However, the stated copayments or coinsurance for Medicare recipients will not be waived.

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

If you are enrolled in Medicare, you may be asked by a physician to sign a private contract agreeing that you can be billed directly for services that would ordinarily be covered by Medicare. Should you sign such an agreement, Medicare will not pay any portion of the charges, and you may receive less or no payment for those services under this Plan.

### **When you also enroll in a Medicare prepaid plan**

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

### **Medicare's payment and this Plan**

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

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

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

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## **This Plan and Medicare** *continued*

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

### **How to claim benefits**

In most cases, when services are covered by both Medicare and this Plan, Medicare is the primary payer if you are an annuitant and this Plan is the primary payer if you are an employee. Your provider should submit your claims to Medicare and, after Medicare has paid its benefits, this Plan will consider the balance of any covered expenses. This Plan has contracted with Medicare Part B carriers to receive electronic copies of your claims after Medicare has paid their benefits. This eliminates the need for you to submit your Part B claims to this Plan. Your copy of the Plan's explanation of benefits will indicate if your claims are being filed electronically. If they are not, you must submit the Medicare Summary Notice with duplicates of all bills and a completed claim form. This Plan will not process your claim until the Medicare Summary Notice is received.

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## **Enrollment Information**

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### **If you are a new member**

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Carrier. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Carrier. See "How to claim benefits" on page 20.

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

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system (see "Effective date" on page 29). Coverage under your new plan for a hospitalized member may be delayed if you are currently enrolled in another FEHB plan and you or a covered family member are hospitalized on the effective date of your enrollment; see "If you are hospitalized" below.

No FEHB plan may refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

### **If you are hospitalized**

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

### **Your responsibility**

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

### **Things to keep in mind**

- The **benefits** in this brochure are effective on January 1 for those already enrolled in this Plan. If you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new **rates** are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).

## **Enrollment Information** *continued*

- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period.
- You will not be informed by your employing office (or your retirement system) or your Carrier when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Carrier does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Carrier promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

You may also remain enrolled in this Plan when you join a Medicare prepaid plan. See page 25 for how this Plan's benefits are affected when you are enrolled in a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

### **Coverage after enrollment ends**

#### **Former spouse coverage**

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she will generally be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

#### **Temporary continuation of coverage (TCC)**

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

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

## Enrollment Information *continued*

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

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

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

### Notification and election requirements:

- **Separating employees** — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.
- **Children** — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.
- **Former spouses** — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

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

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

### Conversion to individual coverage

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

### Certificate of Creditable Coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB plan to cover you. This certificate, along with any certificates you receive from other FEHB plans you may have been enrolled in, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

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## Definitions

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<b>Accidental injury</b>	A bodily injury sustained solely through violent, external and accidental means.
<b>Admission</b>	The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.
<b>Assignment</b>	An authorization by an enrollee or spouse for the Carrier to issue payment of benefits directly to the provider. The Carrier reserves the right to pay the member directly for all covered services.
<b>Calendar year</b>	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
<b>Congenital anomaly</b>	A condition existing at or from birth which is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include protruding ear deformities, cleft lips, cleft palates, birthmarks, webbed fingers or toes and other conditions that the Carrier may determine to be congenital anomalies. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structures supporting the teeth.
<b>Cosmetic surgery</b>	Any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.
<b>Custodial care</b>	<p>Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include but are not limited to:</p> <ol style="list-style-type: none"><li>1) personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;</li><li>2) homemaking, such as preparing meals or special diets;</li><li>3) moving the patient;</li><li>4) acting as companion or sitter;</li><li>5) supervising medication that can usually be self administered; or</li><li>6) treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.</li></ol> <p>The Plan determines which services are custodial care.</p>
<b>Durable medical equipment</b>	<p>Equipment and supplies that:</p> <ol style="list-style-type: none"><li>1) are prescribed by your attending doctor;</li><li>2) are medically necessary;</li><li>3) are primarily and customarily used only for a medical purpose;</li><li>4) are generally useful only to a person with an illness or injury;</li><li>5) are designed for prolonged use; and</li><li>6) serve a specific therapeutic purpose in the treatment of an illness or injury.</li></ol>
<b>Effective date</b>	<p>The date the benefits described in this brochure are effective:</p> <ol style="list-style-type: none"><li>1) January 1 for continuing enrollments and for all annuitant enrollments;</li><li>2) the first day of the first full pay period of the new year for enrollees who change plans or options or elect FEHB coverage during the open season for the first time; or</li><li>3) for new enrollees during the calendar year, but not during the open season, the effective date of enrollment as determined by the employing office or retirement system.</li></ol>
<b>Experimental or investigational</b>	<p>A drug, device or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.</p> <p>A medical treatment or procedure, or a drug, device, or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.</p>

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## Definitions *continued*

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

If you wish to obtain information concerning the experimental/investigational determination process, please contact the Plan.

### **Group health coverage**

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

### **Hospice care program**

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.

### **Incurred date**

The date when the service or supply is received. The benefits that apply are those in effect on the date the charge is incurred.

### **Medically necessary**

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

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

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

### **Mental conditions/ substance abuse**

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

### **Morbid obesity**

A condition wherein an individual: 1) is the greater of 100 pounds or 100% over normal weight with complicating medical conditions; and 2) has been so despite documented attempts to reduce, using a doctor-monitored diet and exercise program.

### **Pre-admission testing**

Routine tests ordered by a doctor and usually required prior to surgery or hospital inpatient admission that are not diagnostic in nature.

### **Reasonable and customary**

The benefits of this Plan are limited to, and based on, reasonable and customary charges, except for negotiated rates with PPO providers, Network retail pharmacies and mail order pharmacies. The reasonable and customary charge for any service or supply is the prevailing charge made by other providers within the geographic area in which the service or supply is provided for illness or injury of comparable severity and nature in the absence of insurance. The Plan determines reasonable and customary charges for inpatient and outpatient Surgical Benefits from data prepared by the Health Insurance Association of America (HIAA). For physician and other professional services and laboratory and X-ray procedures under Other Medical Benefits, the Plan uses data prepared by Medical Data Research (MDR). The Plan pays claims based on the 90th percentile for HIAA and MDR. This data is updated twice per year. For other categories of benefits and for certain specific services within each of the above categories, exceptions to the general method of determining reasonable and customary may exist.

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## ***Non-FEHB Benefits Available to Plan Members***

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

The following non-FEHB Program benefit is available only to letter carriers who are members in good standing with the National Association of Letter Carriers, their spouses, children and retired NALC members.

### **Hospital Plus (hospital indemnity)**

Hospital Plus is a hospital indemnity policy available for purchase from the U.S. Letter Carriers Mutual Benefit Association.

Hospital Plus means money in your pocket when you are hospitalized, from the first day of your stay up to one full year. These benefits are not subject to federal income tax.

Hospital Plus allows you to choose the amount of coverage you need. You may elect to receive up to \$1,500 a month, \$50 a day or up to \$900 a month with the \$30 a day plan. Members and their spouses may select these plans. Children's coverages are limited to either \$30 a day or \$18 a day plans.

Use your benefits to pay for travel to and from the hospital, childcare, medical costs not covered by health insurance, legal fees, or any other costs.

This plan is available to all qualified members regardless of their age. Hospital Plus is renewable for life—you may keep your policy for as long as you like, regardless of benefits you have received or future health conditions.

For more information, please call the United States Letter Carriers Mutual Benefit Association at 202/638-4318 Monday through Friday or 1-800/424-5184 Tuesdays and Thursdays, 8:00 a.m. - 3:30 p.m. EST.

***Benefits on this page are not part of the FEHB contract.***

# ***How NALC Health Benefit Plan Changes January 1999***

Do not rely entirely on this page; it is not a complete statement of benefits. Please review the official brochure in its entirety.

## **Program-wide Changes**

- The medical management of mental conditions will be covered under this Plan's Other Medical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits. Office visits for the medical aspects of treatment do not count toward the 30 outpatient Mental Conditions visit limit.
- The definition of experimental or investigational (see pages 29-30) has been clarified to include biological products.
- If you are enrolled in Medicare, you may be asked by a physician to sign a private contract, agreeing that you can be billed directly for services that would ordinarily be covered by Medicare. Should you sign such an agreement, Medicare will not pay any portion of the charges, and you may receive less or no payment for those services by this Plan.
- The States designated as medically underserved have changed for 1999. Idaho and North Dakota have been added, and West Virginia is no longer underserved. See page 5 for information on medically underserved areas.

## **Changes to this Plan**

- The calendar year deductible has been decreased from \$350 to \$275 per year per person (up to a \$550 family limit) applicable to Other Medical Benefits, Surgical Benefits, and Maternity Benefits.
- The members' family out-of-pocket expenses under the Catastrophic Protection Benefit has been decreased as follows:
  - Under PPO benefits: from \$6,000 to \$3,000 per family.
  - Under Non-PPO benefits: from \$7,000 to \$3,500 per family.
- The Plan's rate of reimbursement for PPO providers under Surgical Benefits has been increased from 80% to 85% of the negotiated rate.

## Summary of Benefits for the NALC Health Benefit Plan — 1999

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). All items below with an asterisk (\*) are subject to the \$275 calendar year deductible.

Benefits		Plan pays/provides	Page
<b>Inpatient care</b>	<b>Hospital</b>	<b>PPO benefit:</b> 100% of room, board and other charges, no deductible <b>Non-PPO benefit:</b> After a \$100 deductible per admission; 80% for ward or semiprivate accommodations; 80% of other hospital charges	10 - 11
	<b>Surgical</b>	<b>PPO benefit:</b> 85%* of the surgeon's negotiated rate <b>Non-PPO benefit:</b> 70%* of reasonable and customary charges	11 - 13
	<b>Medical</b>	<b>PPO benefit:</b> 80%* of the doctor's negotiated rate <b>Non-PPO benefit:</b> 70%* of the doctor's reasonable and customary charges	16 - 17
	<b>Maternity</b>	Same benefits as for illness or injury	14
	<b>Mental Conditions/ Substance Abuse</b>		
	<b>Mental Conditions</b>	<b>PPO benefit:</b> After a \$400 deductible, 50% of PPO hospital charges up to a maximum of 50 days per year <b>Non-PPO benefit:</b> After a \$500 deductible per admission, 50% for ward or semiprivate accommodations and other hospital charges, up to a maximum of 50 days per year	15
	<b>Substance Abuse</b>	After a separate \$250 calendar year Substance Abuse deductible, 50% of charges for up to 30 days of care while confined in a treatment facility, per lifetime	15
<b>Outpatient care</b>	<b>Hospital</b>	<b>PPO benefit:</b> 80%* of the negotiated rate <b>Non-PPO benefit:</b> 70%* of reasonable and customary charges	16 - 17
	<b>Surgical</b>	<b>PPO benefit:</b> 85%* of the surgeon's negotiated rate <b>Non-PPO benefit:</b> 70%* of reasonable and customary charges related to and on the day of surgery	11 - 13
	<b>Medical</b>	<b>PPO benefit:</b> \$15 copay per covered office visit; other benefits, 80%* of the negotiated rate <b>Non-PPO benefit:</b> 70%* of reasonable and customary charge for outpatient physician office visits; 70%* of reasonable and customary charges for other medical services	16 - 17
	<b>Maternity</b>	Same benefits as for illness or injury	14
	<b>Home Health Care</b>	No current benefit	
	<b>Mental Conditions/ Substance Abuse</b>	<b>PPO benefit:</b> After satisfaction of a \$250 calendar year deductible, 60% of charges for 30 visits per year. <b>Non-PPO benefit:</b> After satisfaction of a \$250 calendar year deductible, 50% of charges for 30 visits per year	15
<b>Emergency care (accidental injury)</b>	100% for nonsurgical outpatient services and supplies for care of injury when incurred within 48 hours after accident; charges incurred after 48 hours are considered as Other Medical Benefits	18	
<b>Prescription drugs</b>	<b>Pharmacy:</b> From a Network retail pharmacy (after the \$25 per individual/\$50 per family prescription drug deductible) you pay a copayment of \$5 per generic, \$10 per name brand per prescription or refill. From a non-Network pharmacy, after the \$25 per individual/\$50 family drug deductible, you pay 40% (the Plan pays 60%) of covered charges <b>Mail order:</b> You pay a copayment of \$12 generic and \$25 name brand per prescription or refill	18 - 19 18 - 19	
<b>Dental care</b>	No current benefit		
<b>Additional benefits</b>	Childhood immunizations, Pap smears, Skilled nursing care, Skilled nursing facility, Well child care	18	
<b>Protection against catastrophic costs</b>		<b>PPO benefit:</b> Plan pays 100% when PPO out-of-pocket expenses for Inpatient Hospital, Surgical, Maternity and Other Medical Benefits total more than \$3,000 per individual or \$3,000 per family. <b>Non-PPO benefit:</b> Plan pays 100% when non-PPO out-of-pocket expenses for Inpatient Hospital, Surgical, Maternity, Other Medical Benefits and Additional Benefits (Skilled nursing facility only) total more than \$3,500 per individual or \$3,500 per family. Whether or not you use PPO providers, your share of out-of-pocket expenses will not exceed \$3,500 per individual or \$3,500 per family in a calendar year.	22 22
	<b>Mental Conditions</b>	The Plan pays 100% when out-of-pocket expenses (50% coinsurance) for inpatient mental conditions reach \$8,000 per person in a calendar year, but not to exceed the 50-day calendar year maximum.	22

## 1999 Rate Information for NALC Health Benefit Plan

FEHB Benefits of this Plan are described in this brochure (71-9).

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

**Postal rates** apply to most career U.S. Postal Service employees, but do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	321	\$ 72.06	\$43.14	\$156.13	\$ 93.47	\$ 84.98	\$30.22
Self and Family	322	\$160.39	\$85.79	\$347.51	\$185.88	\$183.29	\$62.89



# Aetna U.S. Healthcare™

1999

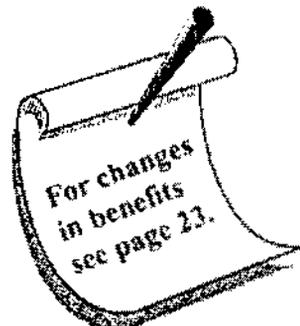
## A Health Maintenance Organization

Enrollment in this Plan is limited; see page 9 for requirements.

Serving: Southwestern and Central Pennsylvania.

Enrollment code:

- KL1 Self Only (High Option)
- KL2 Self and Family (High Option)
- KL4 Self Only (Standard Option)
- KL5 Self and Family (Standard Option)



Serving: Southeastern Pennsylvania.

Enrollment code:

- SU1 Self Only (High Option)
- SU2 Self and Family (High Option)
- SU4 Self Only (Standard Option)
- SU5 Self and Family (Standard Option)

Serving: New Jersey.

Enrollment code:

- P31 Self Only (High Option)
- P32 Self and Family (High Option)
- P34 Self Only (Standard Option)
- P35 Self and Family (Standard Option)

Visit the OPM website at <http://www.opm.gov/insure> and this Plan's website at <http://www.aetnaushc.com/fcds>

Authorized for distribution by the:



United States  
Office of  
Personnel  
Management



RI 73-052

# Aetna U.S. Healthcare

Aetna U.S. Healthcare, Inc., 1425 Union Meeting Road, P.O. Box 3013, Blue Bell, PA 19422, has entered into a contract (CS 1766) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called Aetna U.S. Healthcare or the Plan.

This brochure is the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the benefits stated in this brochure. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1999, and are shown on page 23 of this brochure.

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## **Inspector General Advisory: Stop Health Care Fraud!**

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Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation — sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 1-800/537-9384 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

**THE HEALTH CARE FRAUD HOTLINE  
202/418-3300**

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

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

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## **General Information**

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### **Confidentiality**

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

### **If you are a new member**

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

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

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on page 15. If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See "If you are hospitalized" on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

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## General Information *continued*

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### If you are hospitalized

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

### Your responsibility

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

### Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" on page 3. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- A member with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions, including divorces, of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

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## General Information *continued*

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Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. See page 21 for information on the Medicare prepaid plan offered by this Plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

### Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member also may be eligible for one of the following:

#### Former spouse coverage

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

#### Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

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

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

#### Notification and election requirements

**Separating employees** — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office will notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

**Children** — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

**Former spouses** — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the

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## General Information *continued*

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qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

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

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

### **Conversion to individual coverage**

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

### **Certificate of Creditable Coverage**

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB Plan to cover you. This certificate, along with any certificates you receive from other FEHB plans you may have been enrolled in, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

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## Facts about this Plan

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This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO). When you enroll in an HMO, you are joining an organized system of health care that arranges in advance with specific doctors, hospitals and other providers to give care to members and pays them directly for their services. Benefits are available only from Plan providers except during a medical emergency. Members are required to select a personal doctor from among participating Plan primary care doctors. Services of a specialty care doctor can only be received by referral from the selected primary care doctor. There are no claim forms when Plan doctors are used.

Your decision to join an HMO should be based on your preference for the plan's benefits and delivery system, not because a particular provider is in the plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

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### Information you have a right to know

All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling the Carrier at 1-800-537-9384 or you may write the Carrier at 1425 Union Meeting Road, P.O. Box 3013, Blue Bell, PA 19422. You may also contact the Carrier by fax at 1-215-775-5870 or at its website at <http://www.aetnaushc.com/feds>.

Information that must be made available to you includes:

- Disenrollment rates for 1997.
- Compliance with State and Federal licensing or certification requirements and the dates met. If noncompliant, the reason for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

### Who provides care to Plan members?

This Plan is an individual-practice prepayment Plan. Plan participating providers are neither agents nor employees of the Plan. They are independent doctors who practice in their own offices. Covered benefits are available only from those doctors and from participating hospitals and participating pharmacies. The Plan arranges with doctors and hospitals to provide medical care for both the prevention of disease and the treatment of serious illness.

You must select a primary care doctor for each covered family member. Your primary care doctor must be a family or general practitioner, pediatrician or medical internist. You must contact your primary care doctor for a referral before seeing any other doctor or obtaining specialty services. A wide variety of Board eligible and Board certified specialists are participating Plan doctors. Your Plan primary care doctor or the specialist to whom you were referred admits you to his/her hospital for elective procedures.

### Role of a primary care doctor

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when you have been referred by your primary care doctor, with the following exception: open access to Plan participating gynecologists is available for the diagnosis and treatment of gynecological problems and one routine gynecological exam and Pap smear each calendar year.

### Choosing your doctor

You must select a primary care doctor from the provider directory that corresponds to the enrollment code you selected.

The Plan's provider directory lists participating primary care doctors (general or family practitioners, pediatricians, and internists), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling or writing the Member Relations Department, Aetna U.S. Healthcare, 1425 Union Meeting Road, P.O. Box 3013, Blue Bell, PA 19422 — Telephone: 1-800/537-9384; you can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is

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## **Facts about this Plan** *continued*

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listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed.

If you enroll, you will be asked to complete a primary care doctor selection form and send it directly to the Plan, indicating the name of the primary care doctor(s) you selected for you and each member of your family. Members may change their doctor selection by notifying the Plan 30 days in advance.

If you are receiving services from a doctor who leaves the Plan, the Plan will provide payment for covered services until the Plan can make reasonable and medically appropriate provisions for the assumption of such services by a participating doctor.

### **Plan website**

For the most current list of Plan participating providers, please refer to our Internet Website at [www.aetnaushc.com/feds](http://www.aetnaushc.com/feds). After logging onto our website, click on DocFind.<sup>®</sup> This easy-to-use electronic directory gives you up-to-date provider information. Based on your criteria, a list of providers should appear when available. Clicking directly on the address of the provider gives you detailed information about that provider. DocFind is available 24 hours a day, 7 days a week.

### **Referrals for specialty care**

Except in a medical emergency, or for direct access benefits, or when a primary care doctor has designated another doctor to see patients when he or she is unavailable, you must contact your primary care doctor for a referral before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care doctor's discretion; if specialists or consultants are required beyond those participating in the Plan, the primary care doctor will make arrangements for appropriate referrals.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation. All follow-up care must be provided or authorized by the primary care doctor. On referrals, the primary care doctor will give specific instructions to the consultant as to what services are authorized. If additional services or visits are suggested by the consultant, you must first check with your primary care doctor and obtain another referral. Otherwise you will be responsible for the costs that you incur for services received.

If you have a chronic, complex, or serious medical condition that causes you to see a Plan specialist frequently, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist. The treatment plan will permit you to visit your specialist without the need to obtain further referrals.

### **For new members**

If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral from a Plan primary care doctor for the care to be covered by the Plan. If the doctor who originally referred you prior to joining this Plan is now your primary care doctor, you should call to explain that you now belong to this Plan and ask that a "referral form" be sent to the specialist for your next appointment.

If you are selecting a new primary care doctor, you must schedule an appointment so the primary care doctor can decide whether to treat the condition directly or refer you back to the specialist.

### **Hospital care**

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

### **Out-of-pocket maximum**

Copayments are required for a few benefits. However, copayments will not be required for the remainder of the calendar year after your out-of-pocket expenses for services provided or arranged by the Plan reach 100% of annual premium per Self Only enrollment or 100% of annual premium per Self and Family enrollment (including your premium and the Government's share) under the High Option and \$1,500 per Self Only and \$3,000 per Self and Family enrollment under the Standard Option. This copayment maximum does not include costs of prescription drugs.

You should maintain accurate records of the copayments made, as it is your responsibility to determine when the copayment maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments are due when service is rendered, except for emergency care.

## Facts about this Plan *continued*

### Deductible carryover

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

### Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacitation, provided the claim was submitted as soon as reasonably possible.

### Experimental/investigational determinations

The Plan's medical policy review group uses the Hays Medical Technology Assessment Service, HCFA's policy manual, FDA decisions, etc., to determine which medical procedures are experimental and/or investigational.

### Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

### Reciprocity

When you are beyond a 50-mile radius from home and desire nonemergency or nonurgent care, you can visit a participating primary care doctor in another state or location throughout the Plan's national HMO network. Please call 1-800/537-9384 for provider information. You will be able to choose from 3 primary care doctors in that area and will receive authorization for one visit which includes any tests or X rays required in connection with that visit. Any subsequent visits must be coordinated through your own primary care doctor. You pay a \$5 copay under High Option or a \$15 copay under Standard Option per visit. This benefit is good for up to 30 days away from home.

### The Plan's service areas

The service areas for this Plan, where Plan providers and facilities are located, is described below. Plan providers and facilities in your Service area must be used. You must live or work in one of the service areas to enroll in this Plan. Benefits for care outside a service area are limited to emergency services, as described on page 15 and under the reciprocity benefit.

If you or a covered family member moves outside the service area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

#### Serving: Southwestern and Central Pennsylvania

#### Enrollment Code:

- KL1 Self Only (High Option)
- KL2 Self and Family (High Option)
- KL4 Self Only (Standard Option)
- KL5 Self and Family (Standard Option)

Adams, Allegheny, Armstrong, Beaver, Blair, Butler, Cambria, Carbon, Clarion, Cumberland, Dauphin, Erie, Fayette, Franklin, Greene, Jefferson, Lawrence, Lackawanna, Lancaster, Lebanon, Luzerne, Lycoming, Mercer, Monroe, Northumberland, Perry, Pike, Schuylkill, Snyder, Somerset, Susquehanna, Washington, Wayne, Westmoreland and York counties



1996  
This service area has full  
accreditation from the NCOA. See the  
FEETB Guide for more information on NCOA.

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## Facts about this Plan *continued*

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6/96  
This service area has full accreditation from the NCQA. See the FEIB Guide for more information on NCQA.

Serving: Southeastern Pennsylvania

Enrollment Code:

- SU1 Self Only (High Option)
- SU2 Self and Family (High Option)
- SU4 Self Only (Standard Option)
- SU5 Self and Family (Standard Option)

Berks, Bucks, Chester, Delaware, Lehigh, Montgomery, and Northampton counties and Philadelphia



12/97  
This service area has full accreditation from the NCQA. See the FEIB Guide for more information on NCQA.

Serving: All of New Jersey

Enrollment Code:

- P31 Self Only (High Option)
- P32 Self and Family (High Option)
- P34 Self Only (Standard Option)
- P35 Self and Family (Standard Option)

The State of New Jersey

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## General Limitations

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### Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan.** This brochure is the official statement of benefits on which you can rely.

### Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

### Arbitration of claims

Any claim for damages for personal injury, mental disturbance or wrongful death arising out of the rendition of or failure to render services under this contract must be submitted to binding arbitration.

### Other sources of benefits

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

### Medicare

If you or a covered family member is enrolled in this Plan and Medicare Part A and/or Part B, the Plan will coordinate benefits according to Medicare's determination of which coverage is primary. However, this Plan will not cover services, except those for emergencies, unless you use Plan providers. You must tell your Plan that you or your family member is eligible for Medicare. Generally, that is all you will need to do, unless your Plan tells you that you need to file a Medicare claim.

### Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full or (2) a reduced amount which, when added to the benefits payable by the other

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## General Limitations *continued*

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coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

### **CHAMPUS**

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

### **Medicaid**

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

### **Workers' compensation**

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Program (OWCP) to be payable under workers' compensation (under section §103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

### **DVA facilities, DoD facilities, and Indian Health Services**

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

### **Other Government agencies**

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

### **Liability insurance and third party actions**

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

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## General Exclusions

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All benefits are subject to the limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness or condition.** The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see Emergency Benefits);
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs, or devices that are experimental or investigational;
- Procedures, services, drugs, and supplies related to sex transformations; and
- Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.

## Medical and Surgical Benefits

### What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits and, within the service area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate.

**High Option —** You pay a \$5 copay per visit at your primary doctor office, specialist office, or for laboratory tests and X rays; \$10 copay for a doctor's house call, nothing for home visits by nurses and health aids.

**Standard Option —** You pay a \$10 copay per visit at your primary care doctor office; \$15 copay per visit for specialist office visit, laboratory tests and X rays, or for a doctor's house call, nothing for home visits by nurses and health aids.

The following services are included and are subject to the office visit copay:

- Preventive care, including well-baby care and periodic checkups.
- Mammograms are covered as follows: for women age 35 through 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters.
- Consultations by specialists.
- Diagnostic procedures, including laboratory tests and X rays.
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor (after the first visit, office visit copays are waived for obstetrical care). The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services, including Norplant implantations and IUD insertions.
- Diagnosis and treatment of diseases of the eye.
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum).
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Cornea, heart, heart-lung, lung (single and double), skin, tissue, kidney, liver and pancreas transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan.
- 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.
- Dialysis.
- Chemotherapy, radiation therapy, and inhalation therapy.
- Surgical treatment of morbid obesity.
- Durable medical equipment, such as wheelchairs and hospital beds, orthopedic devices, such as braces, and prosthetic devices, such as artificial limbs, and lenses following cataract removal are covered. Prosthetic devices which are worn externally and replace all or part of an internal body organ or an external body part are covered. Coverage includes repair and replacement when due to growth or normal wear and tear. Replacement, repairs and maintenance not provided for under a manufacturer's warranty or purchase agreement will be covered.

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS.**

## Medical and Surgical Benefits *continued*

- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor who will periodically review the program for continuing appropriateness and need.
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you.

### Limited benefits

**Oral and maxillofacial surgery** is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts and removal of bony-impacted wisdom teeth. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

**Reconstructive surgery** will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

**Short-term rehabilitative therapy** (physical, speech, occupational, and pulmonary) is provided on an outpatient basis for up to two consecutive months per condition if beginning with the first day of treatment, significant improvement can be expected; you pay a \$5 copay under **High Option** and a \$15 copay under **Standard Option** per visit. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Inpatient rehabilitation is covered under Hospital/Extended Care Benefits.

**Diagnosis and treatment of infertility**, including artificial insemination, are covered; you pay a \$5 copay under **High Option** and a \$15 copay under **Standard Option** per visit. The following types of artificial insemination are covered: intravaginal insemination (IVI), intracervical insemination (ICI), and intrauterine insemination (IUI). The cost of donor sperm is not covered. Clomiphene Citrate is covered under the Prescription Drug Benefit. Injectable fertility drugs are not covered. Artificial insemination or surgery for infertility must be preauthorized. Member must contact the Infertility Program Case Manager at 1-800/575-5999 before these treatments are rendered. Infertility care is not covered when the female's follicle-stimulating hormone (FHS) level is above 19 mIU/ml.

**Cardiac rehabilitation** on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure, or a myocardial infarction, is covered for up to three visits a week for a total of 18 visits; you pay a \$5 copay under **High Option** and a \$15 copay under **Standard Option** per visit.

**Chiropractic services** are provided for up to 20 visits per calendar year; you pay a \$5 copay under **High Option** and a \$15 copay under **Standard Option** per visit.

### What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel.
- Immunizations and boosters for travel or work-related exposure.
- Reversal of voluntary, surgically induced sterility.
- Treatment for infertility when the cause of the infertility was a previous sterilization.
- Surgery primarily for cosmetic purposes.
- Homemaker services.
- Hearing aids.
- Transplants not listed as covered.
- Long-term rehabilitative therapy.
- Foot orthotics.
- Dental implants.
- Refractive eye surgery, such as radial keratotomy.
- Blood and blood derivatives, except blood derived clotting factors, and the storage of the patient's own blood for later administration.

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS.**

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## Hospital/Extended Care Benefits

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### What is covered

#### Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay nothing. All necessary services are covered, including:**

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care.
- Specialized care units, such as intensive care or cardiac care units.

#### Extended care

The Plan provides a comprehensive range of benefits with no dollar or day limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **You pay nothing. All necessary services are covered, including:**

- Bed, board and general nursing care.
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.

#### Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

#### Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.

### Limited benefits

#### Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

#### Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 16 for nonmedical substance abuse benefits.

### What is not covered

- Personal comfort items, such as telephone and television.
- Blood and blood derivatives, except blood derived clotting factors, and the storage of the patient's own blood for later administration.
- Custodial care, rest cures, domiciliary or convalescent care.

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS.**

## Emergency Benefits

### 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 the Plan may determine are medical emergencies — what they all have in common is the need for quick action.

### Emergencies within the Service Area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies or if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify your primary care doctor. You or a family member must notify your primary care doctor as soon as possible after receiving emergency care. It is your responsibility to ensure that your primary care doctor has been timely notified.

If you need to be hospitalized, the Plan must be notified as soon as possible. If you are hospitalized in non-Plan facilities and a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

#### Plan pays . . .

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

#### You pay . . .

\$10 under High Option and \$15 under Standard Option per after hours doctor's visit; \$35 under High Option or Standard Option per hospital emergency room or outpatient department visit, or per urgent care center visit for emergency services that are covered benefits of this plan. If the emergency results in admission to a hospital, the copay is waived.

### Emergencies outside the Service Area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified as soon as possible. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

#### Plan pays . . .

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

#### You pay . . .

\$10 under High Option and \$15 under Standard Option per after hours doctor's visit; \$35 under High Option or Standard Option per hospital emergency room or outpatient department visit, or per urgent care center visit for emergency services that are covered benefits of this plan. If the emergency results in admission to a hospital, the copay is waived.

### What is covered

- Emergency care at a doctor's office or an urgent care center.
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services.
- Ambulance service approved by the Plan.

### What is not covered

- Elective care or nonemergency care.
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area.
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.

### Filing claims for non-Plan providers

With your authorization, the Plan will pay emergency benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 22.

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## Mental Conditions/Substance Abuse Benefits

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### Mental conditions

#### What is covered

To the extent shown below, this Plan provides the following services necessary to the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation.
- Psychological testing.
- Psychiatric treatment (including individual and group therapy).
- Hospitalization (including inpatient professional services).

#### Outpatient care

Up to 40 outpatient visits to Plan doctors, consultants or other psychiatric personnel per calendar year; you pay the following for up to 40 visits — all charges thereafter:

##### High Option

Visits 1 and 2 — Nothing

Visits 3–10 — a \$10 copay per visit

Visits 11–40 — a \$25 copay per visit

##### Standard Option

Visits 1–40 — a \$25 copay per visit

#### Inpatient care

Up to 35 days of hospitalization per calendar year; you pay nothing for the first 35 days — all charges thereafter. Inpatient days may be exchanged for outpatient treatment at a rate of four outpatient visits or two partial treatment days for each inpatient day when approved by the Plan.

#### What is not covered

- Care for psychiatric conditions which in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

### Substance abuse

#### What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition. Services for the psychiatric aspects are provided in conjunction with the mental conditions benefit shown above. Outpatient visits to Plan mental health providers for follow-up care and counseling are covered, as well as inpatient services necessary for diagnosis and treatment. The mental conditions visit/day limitations and copays apply.

#### What is not covered

- Treatment that is not authorized by a Plan doctor.

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS.**

## Prescription Drug Benefits

### What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Participating Plan Pharmacy will be dispensed for up to a 34-day supply.

**High Option —** You pay a \$5 copay for generic drugs or for brand name drugs listed on the Plan's formulary and a \$10 copay for nonformulary brand name drugs per prescription unit or refill.

**Standard Option —** You pay a \$10 copay for generic drugs or for brand name drugs listed on the Plan's formulary and a \$15 copay for nonformulary brand name drugs per prescription unit or refill.

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. The Plan's formulary does not exclude medications from coverage, but requires a higher copayment for nonformulary drugs. Nonformulary drugs will be covered when prescribed by a Plan doctor.

Members may obtain up to a 90-day supply of certain maintenance type prescription medication through a participating pharmacy or by mail order. Nonformulary drugs will be covered when prescribed by a Plan doctor and authorized by the Plan. Maintenance drugs are medications that are taken by the general population for extended periods of time such as high blood pressure medications, and do not vary frequently in terms of dosage. Specific maintenance type drugs that are available under this benefit are listed in the Plan's formulary.

**High Option —** You pay a \$10 copay for generic drugs or for brand name maintenance drugs listed in the Plan's formulary and a \$20 copay for nonformulary brand name maintenance drugs.

**Standard Option —** You pay a \$20 copay for generic or for brand name maintenance drugs listed in the Plan's formulary and a \$30 copay for nonformulary brand name maintenance drugs.

To obtain up to a 90-day supply under this benefit, you must first receive a 34-day supply of the maintenance medication and have it filled at a participating pharmacy. Then, up to a 90-day supply may be obtained as follows.

From a participating pharmacy:

- Present a doctor authorized prescription for up to a 90-day supply to the pharmacist for filling. Subsequent refills for up to a 90-day supply will be filled provided the strength and dosage remain the same.

By mail order:

- Call 1-800/537-9384 to obtain the necessary forms.
- Mail the prescription for up to a 90-day supply, along with the appropriate copay, to the Mail Order Pharmacy. Subsequent refills for up to a 90-day supply may be obtained the same way provided the strength and dosage remain the same.

You have up to 45 days after finishing your previous supply (according to your doctor's prescribed directions) to request a maintenance drug refill. Otherwise, the next refill will be considered an initial prescription and covered up to a maximum 34-day supply.

Covered medications and accessories of the pharmacy benefit include:

- Drugs for which a prescription is required by law.
- Oral contraceptive drugs (you may be able to receive up to a 90-day supply through the maintenance drug program).
- Insulin.
- Disposable needles and syringes needed to inject covered prescribed medication, including insulin.
- Diabetic supplies limited to lancets, alcohol swabs, urine test strips/tablets, and blood glucose test strips.
- Clomiphene Citrate.
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria when administered under the direction of a Plan doctor.

Intravenous fluids and medications for home use, implantable drugs, such as Norplant, IUDs and some injectable drugs are covered under Medical and Surgical Benefits.

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS.**

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## Prescription Drug Benefits *continued*

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### Limited benefits

- Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits. You pay a \$15 copay up to the dosage limits and all charges above that.
- Depo Provera, limited to five vials per calendar year. You pay a \$10 copay under High Option and \$20 copay under Standard Option.

### Additional benefits

- One diaphragm per calendar year. You pay a \$5 copay under High Option and \$10 copay under Standard Option.
- Drugs obtained at a nonparticipating pharmacy for an out-of-area emergency (must be beyond a 50-mile radius of a participating pharmacy) are reimbursed at 100% of the cost of the prescription, less the applicable copay. Reimbursements are subject to professional review.

### What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available.
- Drugs obtained at a non-Plan pharmacy.
- Vitamins and nutritional substances that can be purchased without a prescription.
- Medical supplies such as dressings and antiseptics.
- Drugs for cosmetic purposes.
- Drugs to enhance athletic performance.
- Smoking-cessation drugs and medication, including, but not limited to, nicotine patches and sprays.
- Fertility drugs except Clomiphene Citrate.
- Drugs used for the purpose of weight reduction (i.e., appetite suppressants).

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS.

## Other Benefits

### Dental care

#### What is covered

**High Option and Standard Option** — The following dental services are covered when provided by your Plan primary care dentist. If you should require additional dental services, your primary care dentist will provide these services at reduced fees. A partial list appears below. Please consult your participating dentist for a complete schedule of current reduced member fees. All member fees must be paid directly to the participating dentist. **You pay a \$5 copay per visit for the following procedures:**

#### DIAGNOSTIC

Oral evaluations  
All X rays  
Diagnostic models

#### PREVENTIVE

Prophylaxis (cleaning of teeth) every 6 months  
Topical fluoride — every 6 months (child under age 18)  
Oral hygiene instruction

#### RESTORATIVE (Fillings)

Amalgam (primary) 1 surface  
Amalgam (primary) 2 surfaces  
Amalgam (primary) 3 surfaces

#### RESTORATIVE (Fillings) *continued*

Amalgam (primary) 4 surfaces  
Amalgam (permanent) 1 surface  
Amalgam (permanent) 2 surfaces  
Amalgam (permanent) 3 surfaces  
Amalgam (permanent) 4 surfaces

#### PROSTHODONTICS REMOVABLE

Denture adjustments (complete or partial/  
upper or lower)

#### ENDODONTICS (Root Canal)

Pulp cap — direct  
Pulp cap — indirect

The following procedures are available from your Plan primary care dentist. These same services received from a Plan specialist may require you to pay a fee that is higher than the stated maximum. Call your Plan primary care dentist or Plan dental specialist for the specific fee in your area.

	You pay up to a maximum		You pay up to a maximum
<b>DIAGNOSTIC</b>		<b>PROSTHODONTICS FIXED (continued)</b>	
Sealant — per permanent tooth	\$32	Cast metal retainer for resin bonded prosthesis	\$237
Space maintainer	\$418	Crown porcelain	\$645
<b>RESTORATIVE (Fillings)</b>		Crown cast	\$652
Resin (anterior) 1 surface	\$79	Recement bridge	\$62
Resin (anterior) 2 surfaces	\$105	Post and core	\$235
Resin (anterior) 3 surfaces	\$131	<b>ORAL SURGERY</b>	
Resin (anterior) 4 or more surfaces or incisal angle	\$139	Extractions (nonsurgical and tissue impacted)	\$357
Metallic inlay	\$545	Anesthesia (general in office, first half-hour session)	\$202
<b>PROSTHODONTICS REMOVABLE</b>		<b>PERIODONTICS (Gum Treatment)</b>	
Complete denture (upper or lower)	\$770	Gingivectomy per quadrant	\$236
Immediate denture (upper or lower)	\$834	Gingival curettage per quadrant	\$114
Partial denture resin base (upper or lower)	\$593	Periodontal surgery	\$570
Partial denture cast metal framework with resin base (upper or lower)	\$901	Provisional splinting	\$118
Denture repairs	\$113	Scaling and root planing per quadrant	\$114
Add tooth to existing partial	\$100	Periodontal maintenance procedure	\$80
Add clasp to existing partial	\$113	<b>ENDODONTICS (Root Canal)</b>	
Denture rebase	\$285	Therapeutic pulpotomy	\$93
Denture relines	\$245	Root canals (anterior, bicuspid, molar) excluding final restoration	\$571
Interim denture (complete or partial/ upper or lower)	\$349	Apicoectomy — anterior	\$382
Tissue conditioning	\$81	<b>ORTHODONTICS (Braces)</b>	
<b>PROSTHODONTICS FIXED</b>		Pre-orthodontic treatment visit	\$263
Bridge pontic	\$645	Fully banded case (adult age 19 and over)	\$4,395
Metallic inlay/onlay	\$612	Fully banded case (child age 18 and under)	\$4,395

#### What is not covered

Services not received from a participating dental provider.

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS.**

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## Other Benefits *continued*

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### Vision Care

#### What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, the Plan provides the following vision care benefits when received from Plan providers.

- Routine eye refraction based on the schedule below, including a written lens prescription. You pay a \$5 copay under **High Option** and a \$15 copay under **Standard Option**.
- If member wears eyeglasses or contact lenses, an eye refraction may be obtained as follows:
  - Member age 1 through 18 — once every 12-month period.
  - Member age 19 and over — once every 24-month period.
- If member does not wear eyeglasses or contact lenses, an eye refraction may be obtained as follows:
  - Member to age 45 — once every 36-month period.
  - Member age 45 and over — once every 24-month period.
- Up to \$70 reimbursement per 24-month period for corrective eyeglasses and frames or contact lenses (hard or soft lenses).

#### What is not covered

- Eye exercises.
- Fitting of contact lenses.

**CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS.**

## Non-FEHB Benefits Available to Plan Members

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

### Member Health Management

Our wellness and preventive programs provide you with access to materials and services to promote, in conjunction with advice from your physician, a healthy lifestyle and good health.

The new **Healthy Eating™ Program** is an easy-to-follow approach to better health through good nutrition. It's designed to provide members and their families with information to develop a long-term healthful eating plan that is also realistic. Members will also understand how to lower the amount of fat in their diets and become more physically active.

Our **Healthy Breathing® Smoking-Cessation Program** will help you safely quit smoking with educational materials, phone support and discounts on over-the-counter smoking-cessation products. The member may also enroll in an eight- to twelve-week smoking-cessation program.

### Women's Health for Life Programs

Our proactive programs encourage women to receive yearly primary and preventive gynecologic care with emphasis on cervical and breast cancer screening.

The **L'ill Applesed® Program** provides risk screening and assistance for all pregnant members. We also offer special benefits such as educational literature about pregnancy and childbirth, \$40 reimbursement for attending prenatal classes, nurse visits, and discounts on baby care products.

Our **Infertility Program** provides extensive help and services to enhance the chances of pregnancy for couples having difficulty conceiving.

### Vision Care

You are eligible to receive substantial discounts on eyeglasses, contact lenses and nonprescription items such as sunglasses and contact lens solutions through the **Vision One® Program** (1-800-793-8616) at more than 6,000 locations across the country.

This discount enriches our routine vision care coverage, which includes an eye exam from a participating provider. Additionally, it may include coverage for a portion of the cost of prescription eyeglasses or contact lenses.

### National Medical Excellence Program®

Our **National Medical Excellence Program** coordinates services for complicated or rare illnesses and transplants. The National Medical Excellence Program is unique to Aetna U.S. Healthcare and has been created for members with particularly difficult conditions such as rare cancers and other complicated diseases and disorders.

Usually, the recommended treatment can be found in your area. But if your needs extend beyond your region, the National Medical Excellence Program may be available to send you to out-of-area experts.

The first priority is to determine an appropriate treatment program. If your treatment program cannot be provided in the local area, Aetna U.S. Healthcare will arrange and pay for your care as well as related travel expenses to wherever the necessary care is available.

### Medicare Prepaid Plan Enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 4, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-800/832-2640 for information on the Medicare prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-800/832-2640 for information on the benefits available under the Medicare HMO.

***Benefits on this page are not part of the FEHB contract.***

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## How to Obtain Benefits

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### Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Membership Services Office at 1-800/537-9384 or 1-800/628-3323 (Hearing Impaired-TDD), or you may write to the Plan at 1425 Union Meeting Road, P.O. Box 3013, Blue Bell, PA 19422. You may also contact the Plan by fax at 1-215/775-5870 or at its website at <http://www.netmushe.com/feds>.

### Disputed claims review

#### Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

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

#### OPM review

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

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

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

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to:

Office of Personnel Management  
Office of Insurance Programs  
Contracts Division IV  
P.O. Box 436  
Washington, D.C. 20044

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## How to Obtain Benefits *continued*

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You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

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

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## How Aetna U.S. Healthcare Changes January 1999

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Do not rely on this page; it is not an official statement of benefits.

### Program-wide changes

Several changes have been made to comply with the President's mandate to implement the recommendations of the Patient Bill of Rights.

- If you have a chronic, complex, or serious medical condition that causes you to frequently see a Plan specialist, your primary care doctor will develop a treatment plan with you and your health Plan that allows an adequate number of direct access visits with that specialist, without the need to obtain further referrals (see page 8 for details).
- A medical emergency is defined as 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 (see page 15).
- The medical management of mental conditions will be covered under this Plan's Medical and Surgical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits. Office visits for the medical aspects of treatment do not count toward the 40 outpatient Mental Conditions visit limit.

### Changes to this Plan

- Infertility services have decreased. In Vitro fertilization (IVF), Zygote Intra-Fallopian Transfer (ZIFT) and Gamete Intra-Fallopian Transfer (GIFT) procedures are excluded.
- The Standard Option copay for vision care is \$15.
- The office visit copay for dental care is \$5.
- The copays for various dental procedures have changed. See page 19.

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## *Notes*

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## Summary of Benefits for Aetna U.S. Healthcare—1999

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated, subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE AND SERVICES AVAILABLE AS POS BENEFITS FOR STANDARD OPTION ONLY, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.

Benefits	High option pays/provides	Page	Standard option pays/provides	Page
<b>Inpatient care</b>	<b>Hospital</b> Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay nothing .....	14	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay nothing .....	14
	<b>Extended care</b> All necessary services, no dollar or day limit. You pay nothing .....	14	All necessary services, no dollar or day limit. You pay nothing .....	14
	<b>Mental conditions</b> Diagnosis and treatment of acute psychiatric conditions for up to 35 days of inpatient care per calendar year. You pay nothing .....	16	Diagnosis and treatment of acute psychiatric conditions for up to 35 days of inpatient care per calendar year. You pay nothing .....	16
	<b>Substance abuse</b> Covered under Mental Conditions benefit .....	16	Covered under Mental Conditions benefit .....	16
<b>Outpatient care</b>	Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X rays; complete maternity care. You pay a \$5 copay per visit (after the first visit, office visit copays are waived for the maternity care); \$10 copay per house call by a doctor) .....	12	Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X rays; complete maternity care. You pay a \$10 copay for primary care or a \$15 copay for specialist care per visit (after the first visit, office visit copays are waived for the maternity care); \$15 copay per house call by a doctor .....	12
	<b>Home health care</b> All necessary visits by nurses and health aides. You pay nothing per visit .....	12	All necessary visits by nurses and health aides. You pay nothing per visit .....	12
	<b>Mental conditions</b> Up to 40 outpatient visits per calendar year. You pay the following .....	16	Up to 40 outpatient visits per calendar year. You pay a \$25 copay per visit .....	16
	Visits 1 and 2 — covered in full Visits 3-10 — a \$10 copay per visit Visits 11-40 — a \$25 copay per visit			
<b>Substance abuse</b> Covered under Mental Conditions benefit .....	16	Covered under Mental Conditions benefit .....	16	
<b>Emergency care</b>	Reasonable charges for services required because of a medical emergency. You pay a \$10 copay after hours at primary doctor's office; a \$35 copay to the hospital for each emergency room visit and any charges for services not covered by this Plan .....	15	Reasonable charges for services required because of a medical emergency. You pay a \$15 copay after hours at primary doctor's office; a \$35 copay to the hospital for each emergency room visit and any charges for services not covered by this Plan .....	15
<b>Prescription drugs</b>	Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. You pay a \$5 copay for generic drugs or formulary brand name drugs and a \$10 copay for nonformulary brand name drugs per prescription unit or refill. Maintenance type drugs are available for up to a 90-day supply; you pay a \$10 copay for generic drugs or formulary brand name drugs and a \$20 copay for nonformulary drugs .....	17	Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. You pay a \$10 copay for generic drugs or formulary brand name drugs and a \$15 copay for nonformulary brand name drugs per prescription unit or refill. Maintenance type drugs are available for up to a 90-day supply; you pay a \$20 copay for generic drugs or formulary brand name drugs and a \$30 copay for nonformulary drugs .....	17
<b>Dental care</b>	Preventive dental care, comprehensive range of restorative, orthodontic and other services. You pay variable copays .....	19	Preventive dental care, comprehensive range of restorative, orthodontic and other services. You pay variable copays .....	19
<b>Vision care</b>	Routine refraction and up to \$70 for eyeglasses or contact lenses per 24-month period. You pay a \$5 copay per visit .....	20	Routine refraction and up to \$70 for eyeglasses or contact lenses per 24-month period. You pay a \$15 copay per visit .....	20
<b>Out-of-pocket maximum</b>	Copayments are required for a few benefits. However, after your out-of-pocket expenses reach a maximum of 100% of annual premium per Self Only enrollment or 100% of annual premium for Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include prescription drugs .....	8	Copayments are required for a few benefits. However, after your out-of-pocket expenses reach a maximum of \$1,500 per Self Only enrollment and \$3,000 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include prescription drugs .....	8

# 1999 Rate Information for Aetna U.S. Healthcare

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

Postal rates apply to most career U.S. Postal Service employees, but do not apply to noncareer Postal employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

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

### All of New Jersey

High Option Self Only	P31	\$72.06	\$60.11	\$156.13	\$130.24	\$84.98	\$47.19
High Option Self and Family	P32	\$160.39	\$168.06	\$347.51	\$364.13	\$183.29	\$145.16

### All of New Jersey

Standard Option Self Only	P34	\$65.40	\$21.80	\$141.70	\$47.23	\$77.39	\$9.81
Standard Option Self and Family	P35	\$160.39	\$67.81	\$347.51	\$146.92	\$183.29	\$44.91

### Southeastern Pennsylvania

High Option Self Only	SU1	\$72.06	\$31.36	\$156.13	\$67.95	\$84.98	\$18.44
High Option Self and Family	SU2	\$160.39	\$114.21	\$347.51	\$247.46	\$183.29	\$91.31

### Southeastern Pennsylvania

Standard Option Self Only	SU4	\$64.55	\$21.51	\$139.85	\$46.61	\$76.38	\$9.68
Standard Option Self and Family	SU5	\$160.39	\$65.93	\$347.51	\$142.85	\$183.29	\$43.03

### Southwestern and Central Pennsylvania

High Option Self Only	KL1	\$64.50	\$21.50	\$139.75	\$46.58	\$76.33	\$9.67
High Option Self and Family	KL2	\$160.39	\$68.85	\$347.51	\$149.18	\$183.29	\$45.95

### Southwestern and Central Pennsylvania

Standard Option Self Only	KL4	\$59.15	\$19.72	\$128.17	\$42.72	\$70.00	\$8.87
Standard Option Self and Family	KL5	\$157.90	\$52.63	\$342.11	\$114.04	\$183.29	\$27.24