

A Fee-for-Service Employee Organization Plan



Sponsored by the American Foreign Service Protective Association

Who may enroll in this Plan: You must be, or become, a member of the American Foreign Service Protective Association.

To become a member: When you enroll in the Foreign Service Benefit Plan, you automatically become a member of the Protective Association. New membership in the Protective Association is limited to American Foreign Service personnel as defined in the Foreign Service Act of 1980 and to other Executive Branch civilian employees assigned overseas with medical clearance from the Department of State or the Department of Defense. Membership is for life. Active employees otherwise eligible for FEHB coverage may continue, or resume, coverage under the Plan.

Annuitants (retirees) may enroll in this Plan, provided they are eligible under the Foreign Service Retirement System.

Membership dues: There are no membership dues.

Enrollment code for this Plan:

401 Self only

402 Self and family

Authorized for distribution by the:



United States
Office of
Personnel
Management



The Foreign Service Benefit Plan

The American Foreign Service Protective Association (Carrier), Washington, DC, has entered into Contract No. CS 1062 with the Office of Personnel Management (OPM) to provide a health benefits plan (Plan) authorized by the Federal Employees Health Benefits (FEHB) law. This Plan is underwritten by the Mutual of Omaha Insurance Company which administers this Plan on behalf of the Carrier and is referred to as Carrier in this brochure. The FEHB contract specifies the manner in which it may be modified or terminated.

This brochure is based on text incorporated into the contract between OPM and the Carrier as of January 1, 1997 and is intended to be a complete statement of benefits available to FEHB members. It describes the benefits, exclusions, limitations, and maximums of the Foreign Service Benefit Plan for 1997 and until amended by future benefit negotiations between OPM and the Carrier. It also describes procedures for obtaining benefits. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. Oral statements cannot modify the benefits described in this brochure.

An enrollee does not have a vested right to receive the benefits in this brochure in 1998 or later years, and does not have a right to benefits available prior to 1997 unless those benefits are contained in this brochure.

Inspector General Advisory: Stop Health Care Fraud!

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

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

- Call the provider (doctor, hospital, etc.) and ask for an explanation — sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Carrier at 202/833-4910 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.

Using This Brochure

The **Table of Contents and Index** will help you find the information you need to make the best use of your benefits.

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

You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on which provider bills for the service. For example, physical therapy is paid one way if it is billed by a Home Health Care provider 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 a hospital, a hospice, a skilled nursing facility or receive home health care you need to read **Precertification**; these services must be precertified for all payable benefits to apply. If you are enrolled in Medicare, take a look at **This Plan and Medicare**. And, the **Enrollment Information** section tells you about several FEHB enrollment requirements that could affect your future coverage.

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How This Plan Works

Help Contain Costs

You can help

FEHB plans are expected to manage their costs prudently. All FEHB plans have cost containment measures in place. All fee-for-service plans include two specific provisions in their benefits packages: precertification of all inpatient admissions and the flexible benefits option. In addition, this Plan requires precertification of home health care, hospice and skilled nursing facility admissions.

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 hospital days required to treat your condition. Precertification is also required for home health care, hospice and skilled nursing facility admissions under this Plan. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with your Carrier before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by \$500. In addition, you or your doctor must check with your Carrier before being admitted to a hospice or skilled nursing facility, or receiving home health care. If that doesn't happen, your Plan will pay reduced benefits. 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 25 and 26 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.

Facilities and Other Providers

Covered facilities

Birthing center

A licensed facility that is equipped and operated solely to provide prenatal care, to perform uncomplicated spontaneous deliveries and to provide immediate postpartum care.

Day care center

A facility licensed as a day care center and that provides a planned program of psychiatric services for patients with mental conditions who must spend their days, but not nights, under psychiatric supervision, and that are not for schooling, custodial, recreational, or training services.

Hospice

A public or private agency or organization that:

- 1) primarily provides inpatient hospice care to terminally ill persons;
- 2) is certified by Medicare as such, or is licensed or accredited as such by the jurisdiction it is in;
- 3) is supervised by a staff of M.D.'s or D.O.'s at least one of whom must be on call at all times;
- 4) provides 24-hour-a-day nursing services under the direction of an R.N. and has a full-time administrator; and
- 5) provides an ongoing quality assurance program.

Facilities and Other Providers *continued*

Hospital

- 1) An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
- 2) Any other institution that is operated pursuant to law, under the supervision of a staff of doctors and with 24-hour-a-day nursing services, and that is primarily engaged in providing:
 - a) General inpatient 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; or
 - b) Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.
- 3) For inpatient and outpatient treatment of alcohol and drug abuse, the term hospital also includes a free-standing alcohol and drug abuse treatment facility approved by the JCAHO.

In no event shall the term hospital include a convalescent nursing home or institution or part thereof that:

- 1) is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged;
- 2) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or
- 3) is operated as a school.

Skilled nursing facility

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

Covered providers

For purposes of this Plan, covered providers include a licensed doctor of medicine (M.D.), a licensed doctor of osteopathy (D.O.), a licensed or certified dentist, or a podiatrist. Other covered providers include a qualified clinical psychologist, clinical social worker, optometrist, nurse midwife, nurse practitioner/clinical specialist, physician assistant 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 1997, the States designated as medically underserved are: Alabama, Louisiana, Mississippi, New Mexico, North Dakota, South Carolina, South Dakota, West Virginia and Wyoming.

Cost Sharing

Deductibles

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

Calendar year

The calendar year deductible is the amount of expenses an individual must incur for covered services and supplies each calendar year before the Plan pays Other Medical Benefits and outpatient treatment of mental conditions. The deductible is \$200 per person and \$400 per family. Expenses are “incurred” on the date on which the service or supply is received.

Cost Sharing *continued*

Hospital

There is a separate deductible of \$175 per person per confinement for hospital room and board expenses. Each family member must satisfy this 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 in the prior year will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

Family limit

There is a separate calendar year deductible of \$200 for each person. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the deductible for all family members reach \$400 during a calendar year.

The calendar year deductible is applied only once in a calendar year regardless of how many different illnesses or accidents a person may have. Furthermore, if two or more covered members of your family are injured in the same accident, you have to pay only one deductible for those members injured in the accident.

Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductible. For instance, when the Plan pays 80% of reasonable and customary charges for a covered service, you are responsible for 20% of the reasonable and customary charges, *i.e.*, the coinsurance. In addition, you are responsible for any excess charge over the Plan's reasonable and customary allowance. For example, if the provider ordinarily charges \$100 for a service but the Plan's reasonable and customary allowance is \$95, the Plan will pay 80% of the allowance (\$76). You must pay the 20% coinsurance (\$19), plus the difference between the actual charge and the reasonable and customary allowance (\$5), for a total member responsibility of \$24.

If provider waives your share

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

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 9), 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.

Lifetime maximums

- The Hospice benefit is limited to \$7,500 per person per lifetime when the hospice care is precertified.
- The Hospice benefit is limited to \$4,500 per person per lifetime when the hospice care is not precertified.
- The Orthodontic benefit is limited to \$1,000 per person per lifetime.
- The Substance abuse benefit is limited to two treatment programs per person per lifetime.
- The Smoking cessation benefit is limited to one per person per lifetime.
- Diagnosis and treatment of infertility is limited to a maximum benefit of \$5,000 per person per lifetime.

General Limitations

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

Other sources of benefits

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

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 26 and 27 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 allowable expenses.

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.

General Limitations *continued*

Liability insurance and third party actions

Subrogation applies when you are sick or injured as a result of the act or omission of another person or party.

Subrogation means the Plan's right to recover any benefit payments made to you or your dependent by a third party's insurer because of an injury or illness caused by a third party. Third party means another person or organization.

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

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

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 1998 or later years, and does not have a right to benefits available prior to 1997 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 more for covered services than 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.

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 amount for the service), **or** actual charge, whichever is lower.

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 **and** any balance up to the limiting charge amount that a provider who does not participate with Medicare is legally permitted to bill under Medicare law (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 even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

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

General Exclusions

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

Benefits are provided only for services and supplies that are medically necessary (see definition on page 32). The Carrier reserves the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

Benefits will not be paid for services and supplies when:

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

Benefits will not be paid for:

- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
- Charges the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 9), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 27), or State premium taxes however applied
- Charges that the Carrier determines to be in excess of the reasonable and customary charge
- Treatment of mental retardation and learning disabilities
- Services for cosmetic purposes
- Non-surgical treatment of temporomandibular joint (TMJ) dysfunction including dental appliances, study models, splints and other devices
- 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

Benefits

Inpatient Hospital Benefits

What is covered

Precertification

The Plan pays for inpatient hospital services as shown below.

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by \$500. See pages 25 and 26 for details.

Waiver

This precertification requirement does not apply to persons whose primary coverage is Medicare Part A or another health insurance policy or when the hospital admission is outside the United States. For information on when Medicare is primary, see pages 26-27.

Room and board

After the \$175 inpatient hospital deductible per person per confinement, the Plan pays **100%** of semiprivate room and board charges.

Semiprivate, ward and intensive care accommodations, including general nursing care, meals, and special diets, are covered. If a private room is used, only the hospital's average semiprivate room rate will be considered a covered expense. However, if the patient's isolation is required to prevent contagion to others, the charge for a private room will be covered.

Other charges

The Plan pays **80%** of reasonable and customary charges for all covered hospital charges other than room and board. The Plan will also pay **80%** of reasonable and customary charges for the following services received while you are in a hospital that are not provided by the hospital:

- Medical (nonsurgical) services of doctors;
- Services of physical therapists; and
- Inpatient private duty nursing services by an R.N. or L.P.N. when the services are rendered outside of North America.

Limited benefits

Pre-admission testing

The Plan pays **100%** of reasonable and customary charges for pre-admission tests received within 72 hours before admission to a hospital and within 72 hours of hospital outpatient surgery.

Hospitalization for dental work

Hospital charges are covered when a nondental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient, even though no benefits may be payable for services of dentists or doctors in connection with the dental treatment. See page 20 for dental services covered by the Plan.

Related benefits

Mental conditions

Charges for hospital expenses for treatment of mental conditions are not covered under Inpatient Hospital Benefits. Coverage for treatment of mental conditions is discussed on page 15.

Professional charges

Charges for professional services of a doctor or any other practitioner covered under this Plan (except as stated above), even though billed by a hospital as part of hospital services, are covered only under Surgical Benefits, Maternity Benefits, Mental Conditions/Substance Abuse Benefits, Other Medical Benefits or Additional Benefits (pages 12-18).

Skilled nursing facility

Benefits provided are covered under Additional Benefits; see page 18.

Prosthetic appliances

Prosthetic appliances (*e.g.*, pacemakers, artificial hips, intraocular lenses) are covered only under Other Medical Benefits (page 16).

Take-home items

Drugs, medical supplies, medical equipment and any covered items billed by a hospital but to be used at home are covered under Other Medical Benefits (page 16).

What is not covered

- Confinement in nursing homes, rest homes, places for the aged, convalescent homes or any place that is not a hospital, skilled nursing care facility or hospice (see Facilities and Other Providers on pages 5 and 6)
- Custodial care (as defined on page 31) even when provided by a hospital
- A hospital admission that is not medically necessary, *i.e.*, the medical services did not require the acute hospital inpatient (overnight) setting, but could have been provided in a doctor's office, the outpatient department of a hospital, or some other setting without adversely affecting the patient's condition or the quality of medical care rendered
- Inpatient private duty nursing except as provided above
- Personal comfort items such as radio, television, telephone, beauty and barber services, ID tags, baby beads, footprints, guest cots, guest meals, newspapers and similar items

Surgical Benefits

What is covered

The Plan pays for the following services:

Hospital inpatient

The Plan pays **90%** of reasonable and customary charges for surgery.

Outpatient

The Plan pays **100%** of reasonable and customary charges for surgery. The Plan also pays all necessary reasonable and customary charges by a hospital, physician, or approved surgicenter for outpatient services and supplies furnished within 72 hours of an outpatient surgical operation. Laboratory tests, tissue pathology, and supplies in relation to office surgery are also covered under this benefit (except as shown on page 13).

Multiple surgical procedures

When multiple or bilateral surgical procedures that add time or complexity to patient care are performed during the same operative session, the Plan pays as follows: the value of the major procedure plus 50% of the value of the lesser procedure(s).

Incidental procedures

When an incidental procedure (*e.g.*, incidental appendectomy, lysis of adhesions, excision of scar) is performed through the same incision, the reasonable and customary allowance will be that of the major procedure only.

Assistant surgeon (inpatient/outpatient)

Charges by an assistant surgeon in connection with inpatient or outpatient surgery are covered at **80%** of reasonable and customary charges when determined by the Carrier to be medically necessary.

Anesthesia

The Plan pays **100%** of reasonable and customary charges for general administration of anesthesia in or out of a hospital.

Organ/tissue transplants and donor expenses

All reasonable and customary charges incurred for a covered surgical transplant, whether incurred by the recipient or donor, will be considered expenses of the recipient and will be covered the same as for any other illness or injury. This benefit applies only if the recipient is covered by the Plan.

Transplant surgery means transfer of a body organ(s) from the donor to the recipient.

Recipient means an insured person who undergoes a surgical operation to receive a body organ(s) transplant.

Donor means a person who undergoes a surgical operation for the purpose of donating a body organ(s) for transplant surgery.

What is covered

- Cornea, heart, kidney, liver, pancreas, heart/lung, single lung and double lung transplants
- Bone marrow and stem cell support as follows:

Allogeneic bone marrow transplants

Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support for 1) acute lymphocytic or non-lymphocytic leukemia; 2) advanced Hodgkin's lymphoma; 3) advanced non-Hodgkin's lymphoma; 4) advanced neuroblastoma; 5) testicular, mediastinal, retroperitoneal and ovarian germ cell tumors; 6) breast cancer; 7) multiple myeloma; and 8) epithelial ovarian cancer

- Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan.

Surgical Benefits *continued*

What is not covered

- Transplants not listed as covered; services or supplies for, or related to, surgical transplant procedures for artificial or human organ transplants not listed as covered.

Oral and maxillofacial surgery

Charges of an oral surgeon (D.D.S. or D.M.D.) for removal of impacted teeth or for a nondental surgical operation performed on the jaw or in the mouth will be covered as shown on page 12. Oral surgery that involves any tooth or tooth structure, alveolar process, abscess, periodontal disease or disease of gingival tissue is not covered by the Plan except as provided under Dental Benefits (see page 20).

Related benefits

Prosthetic appliances

Prosthetic appliances (*e.g.*, pacemakers, artificial hips, intraocular lenses) are covered only under Other Medical Benefits (page 16).

Second opinion (voluntary)

Charges of an independent consulting doctor are covered under Other Medical Benefits (see page 16).

Take-home items

Drugs, medical supplies, medical equipment and any covered items billed by a hospital, physician or approved surgicenter but to be used at home are covered under Other Medical Benefits (page 16).

What is not covered

- Cosmetic surgery (as defined on page 31), except for the repair of accidental injuries sustained while covered under the FEHB Program; to correct a congenital anomaly; or for the reconstruction of a breast that was removed or partially removed while covered under the FEHB Program
- Radial keratotomy
- Treatment or removal of corns and calluses, or trimming of toenails

Maternity Benefits

What is covered

The Plan pays the same benefits for hospital, surgery (delivery), laboratory tests and other medical expenses as for illness or injury.

Inpatient hospital Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Unscheduled or emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Newborn confinements that extend beyond the mother's discharge must also be precertified. If any of the above are not done, the benefits payable will be reduced by \$500. See pages 25 and 26 for details.

Waiver

See page 25 for exceptions to the precertification requirement.

Room and board

After the \$175 inpatient hospital deductible per person per confinement, the Plan pays **100%** of semiprivate room and board charges.

Other charges

The Plan pays **80%** of reasonable and customary charges for all other covered hospital charges, including anesthesia supplies and ambulance.

Bassinet or nursery charges for days on which mother and child are both confined are considered expenses of the mother and not expenses of the child. Charges that are considered expenses of the child are paid only if the child is covered by a family enrollment. Routine circumcision is covered under Surgical Benefits for a newborn child covered by a family enrollment, page 12.

Obstetrical care

Charges of the doctor and/or State licensed midwife (for delivery, prenatal and postnatal visits) and amniocentesis are paid under Surgical Benefits, page 12.

Outpatient care

The Plan pays **100%** of reasonable and customary charges not subject to the calendar year or inpatient hospital deductibles for covered services at the time of delivery when: delivery is on an outpatient basis; delivery is at a licensed birthing center; or inpatient delivery results in a hospital confinement of one day (overnight) or less and no more than one day's room and board charge.

If the mother or newborn child is transferred from a birthing center to a hospital due to medical complications, the birthing center expenses will be paid as shown above. For a confinement of one day (overnight) or less, if the mother and child leave the hospital against medical advice, this benefit is not payable and regular Plan benefits will apply.

Related benefits

Diagnosis and treatment of infertility

Diagnosis and treatment of infertility are covered as Other Medical Benefits, page 17.

Testing

Sonograms, other related tests on the unborn child, and the initial examination of a newborn child are covered as Other Medical Benefits, page 16.

Voluntary sterilization

Voluntary sterilization is covered under Surgical Benefits, page 12.

Well child care

Well child visits to a doctor for children up to age 18 months are covered as Other Medical Benefits, page 16. Childhood immunizations are covered as Additional Benefits, page 18.

For whom

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

What is not covered

- Drugs and devices used for contraceptive purposes, including oral contraceptives and implanted drugs, such as Norplant
- Reversal of voluntary surgical sterilization
- Routine sonograms to determine fetal age and/or size
- Services and supplies related to treatment of impotency
- Assisted Reproductive Technology (ART) procedures, such as artificial insemination, in vitro fertilization, embryo transfer and gamete intrafallopian transfer (GIFT), as well as services and supplies related to ART procedures, are not covered.
- 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.

Mental Conditions/Substance Abuse Benefits

What is covered	The Plan pays for the following services:
Mental conditions	
Inpatient care	The Plan pays 100% of the reasonable and customary hospital expenses for room and board and other hospital charges incurred during the first 30 days of each hospital confinement. After 30 days, the Plan will pay 80% of the covered expenses. Catastrophic protection benefit applies to your covered out-of-pocket expenses for the treatment of mental conditions (see page 24).
Precertification	The medical necessity of your admission to a hospital or other 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 25 and 26 for details.
Waiver	See page 25 for exceptions to the precertification requirement.
Inpatient visits	<p>The Plan pays 80% of reasonable and customary charges for doctors' in-hospital visits for mental conditions up to a maximum Plan payment of \$40 per visit with a limit of 50 visits per calendar year.</p> <p>In addition, benefits for group therapy are payable at actual charges up to a maximum of \$15 per session. Group therapy is not subject to the visit limitation.</p> <p>Charges for professional services of a doctor or any other practitioner covered under this Plan, even though billed by a hospital as part of hospital services, are covered only as specified above.</p>
Outpatient care	<p>After the \$200 calendar year deductible, the Plan covers outpatient care by a doctor, clinical psychologist, clinical social worker, psychiatric nurse, or a nurse practitioner/clinical specialist. The Plan pays 75% of reasonable and customary charges (limited to 60 visits per person per calendar year) for individual visits, including collateral visits if the patient is a child.</p> <p>The Plan pays 75% of reasonable and customary charges for day care in a day care center (limited to 20 visits per person per calendar year), provided the institution meets the definition on page 5.</p> <p>The Plan pays 50% of reasonable and customary charges up to a maximum of \$25 per session for group therapy visits. There is no limit on the number of visits.</p>
Substance abuse	<p>The Plan will pay regular Inpatient Hospital Benefits (refer to page 11) and Other Medical Benefits (refer to page 16) for up to 5 days confinement each calendar year for detoxification in a hospital or an accredited treatment center with detoxification facilities.</p> <p>The Plan also pays 100% of charges up to \$8,000 for one 28-day inpatient substance abuse treatment program in an accredited alcoholic or drug treatment facility per person per calendar year. This benefit also includes an aftercare outpatient treatment program that immediately follows the 28-day inpatient program.</p>
Precertification	Precertification is required to obtain the above benefits for detoxification and/or treatment of substance abuse. Refer to pages 25 and 26 for additional information on how to obtain precertification.
Lifetime maximum	The Substance abuse benefit is limited to two treatment programs per person per lifetime. Withdrawal prior to completion constitutes use of one program. No other Plan benefits are available for the treatment of alcoholism or drug addiction with the exception of the detoxification benefit shown above.
What is not covered	<ul style="list-style-type: none">• Counseling or therapy for marital, educational, sexual or behavioral problems

Other Medical Benefits

What is covered

After the \$200 calendar year deductible has been met, the Plan pays **80%** of reasonable and customary charges for the following:

- Doctors' office visits, home calls, and consultations
- Charges by an independent consulting doctor for services in relation to a second opinion regarding the necessity for anticipated surgery
- Services of a registered physical therapist practicing within the scope of his/her license for administration of physical therapy in accordance with a doctor's specific instructions as to type, frequency and duration
- Speech therapy provided by a licensed speech therapist practicing within the scope of his/her license, but only when necessary to restore speech when there has been a functional loss of speech due to illness or injury, and when therapy is rendered in accordance with a doctor's specific instructions as to type and duration
- Well-child visits through 18 months of age; immunizations are covered under Additional Benefits, page 18
- One pair of eyeglasses or contact lenses per incident if required to correct an impairment directly caused by accidental ocular injury or specifically ordered by the doctor in connection with a diagnosis of cataract, keratoconus or glaucoma
- X-ray services and laboratory tests
- Blood or blood plasma not donated or replaced
- Acupuncture performed by an M.D. or D.O.
- Radium or radioactive isotopes
- Artificial eyes or limbs required to replace natural eyes and limbs
- Casts, splints, trusses, braces or crutches
- Hospital outpatient services and supplies not covered under any other provision of this Plan
- Rental up to the purchase price, or purchase (at the option of the Carrier), of durable medical equipment, such as wheelchair, hospital-type bed, and iron lung
- Oxygen and equipment for its administration
- Chemotherapy
- Radiation therapy
- Local ambulance service to or from the hospital
- Prescription drugs purchased from a pharmacy are covered. See page 19 for instructions on how to file a claim.
- Dental work necessitated by accidental injury to the jaw or sound natural teeth if the accident occurs while covered by the Plan and the service is rendered while covered by this Plan within 24 months of the accident, including expenses of necessary dental X-rays and initial replacement of sound natural teeth
- One external breast prosthesis, and one specially fitted bra for use with the prosthesis, per calendar year, when required due to mastectomy
- **Routine** physical examination, limited to a maximum charge of \$250 per person, per calendar year. Routine mammograms are not covered except as shown below.

Routine services

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

Breast cancer screening

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

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

Cervical cancer screening

Annual coverage of one pap smear for women age 18 and older is included in the Routine physical examination benefit (see above).

Colorectal cancer screening

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

Prostate cancer screening

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

Other Medical Benefits *continued*

Also covered as Routine services are the following:

- From age 19 through 64, one nonfasting total blood cholesterol test every three consecutive calendar years.
- At age 19 and over, one tetanus-diphtheria (Td) booster every 10 consecutive calendar years.
- At age 65 and over, one influenza vaccine and pneumococcal vaccine every calendar year.

Limited Benefits

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.

A statement from the provider certifying completion of the program is required to obtain this benefit.

Diagnosis and treatment of infertility

After the \$200 calendar year deductible, the Plan pays **80%** of reasonable and customary charges, up to \$5,000 per person per lifetime, for the diagnosis and treatment of infertility as defined below.

Diagnosis of infertility includes:

- The initial diagnostic tests and procedures done solely to identify the cause or causes of the inability to conceive.

Treatment of infertility includes:

- Hormone therapy and related services; and
- Medical or surgical services performed solely to create or enhance the ability to conceive.

What is not covered

- Sun or heat lamps, whirlpool baths, heating pads, air purifiers, humidifiers, air conditioners, exercise devices and other items that do not meet the definition of durable medical equipment
- Orthopedic shoes, orthotics and other supportive devices for the feet
- Provocative food testing, end-point-titration techniques and sublingual allergy desensitization
- Routine eye examinations
- Eyeglasses and contact lenses except as shown on page 16
- Eye exercises and visual training (orthoptics)
- Hearing aids and examinations for them, except the initial exam
- Inpatient private duty nursing, except as shown on page 11
- Chelation therapy, except for acute arsenic, gold, mercury or lead poisoning
- Services provided by a chiropractor (except see page 6 regarding medically underserved areas)
- Drugs and services for cosmetic purposes
- Jobst stockings, unless determined to be medically necessary by the Carrier
- Assisted Reproductive Technology (ART) procedures such as artificial insemination, in vitro fertilization, embryo transfer and gamete intrafallopian transfer (GIFT), as well as services and supplies related to ART procedures, are not covered.

Additional Benefits

Accidental injury

The Plan pays **100%** of reasonable and customary charges made by a hospital or doctor for outpatient emergency treatment (with or without surgery) rendered within 72 hours after an accidental injury (see definition). Charges for services after 72 hours are covered under Other Medical Benefits. Emergency treatment is otherwise covered the same as non-emergency treatment.

Childhood immunizations

Childhood immunizations recommended by the American Academy of Pediatrics are covered at **100%** of reasonable and customary charges for covered members under age 22. Associated charges for office visits and other services will be considered under Other Medical Benefits. See page 16.

Emergency ambulance service

The Plan pays **100%** up to \$50 for ambulance service within 72 hours of an accident. Charges over \$50 for local ambulance service are payable under Other Medical Benefits.

Home health care

When precertification is obtained (see pages 25 and 26), the Plan pays **100%** of reasonable and customary charges up to \$80 per visit for a maximum of 90 home health care visits per calendar year, limited to one visit per day, if such care is an alternative to hospitalization.

When precertification is not obtained, the Plan pays **100%** of reasonable and customary charges up to \$40 per visit for a maximum of 40 home health care visits per calendar year, limited to one visit per day, if such care is an alternative to hospitalization.

A home health care visit consists of one of the following:

- Less than an 8 hour shift of nursing care provided on a part-time basis by a registered nurse (RN) or a licensed practical nurse (LPN);
- One session of physical, occupational or speech therapy provided by a licensed therapist;
- One visit from a licensed social worker (limited to two visits per calendar year); or
- Less than an 8 hour shift of a home health aide's services that are performed under the supervision of a registered nurse (RN) and that consists mainly of medical care and therapy provided solely for the care of the insured person.

The above home health care services must be furnished: by a home health agency (or by visiting nurses where services of a home health agency are not available); in accord with a home health care plan (see definition) certified by the member's doctor; and in the insured person's home.

Hospice care

When precertification is obtained (see pages 25 and 26), the Plan pays **100%** of reasonable and customary charges up to a maximum of \$7,500 for hospice care provided by a hospice agency or organization (see definition) to a terminally ill patient in the final stages of illness when such care is recommended by a doctor.

When precertification is not obtained, the Plan pays **100%** of reasonable and customary charges up to a maximum of \$4,500 for hospice care when the above requirements are met.

This benefit does not apply to services shown as covered under any other provisions of this Plan.

Private duty nursing at home

For services rendered by a registered nurse (RN) or licensed practical nurse (LPN) in the home, the Plan will cover up to 500 units per calendar year. One private duty nursing unit consists of up to one hour of private duty nursing care. The Plan pays \$12 per unit and no deductible applies.

Renal dialysis

The Plan pays **100%** of reasonable and customary charges for all covered services and supplies for renal dialysis in or out of a hospital.

Skilled nursing facilities

When precertification is obtained (see pages 25 and 26), if a person is confined in a skilled nursing facility (see definition), the Plan will, for a maximum of 60 days per confinement, pay **100%** of the reasonable and customary charges when:

- the confinement is for the purpose of receiving medical care;
- the confinement is under the supervision of a doctor; and
- the confinement is an alternative to hospitalization.

When precertification is not obtained, the Plan will, for a maximum of 30 days per confinement, pay **80%** of reasonable and customary charges in a skilled nursing facility, provided the above conditions are met.

Skilled nursing facility benefits shown above will be restored for each new period of confinement. There is a new period of confinement when:

- the requirements listed above are met; and
- at least 60 days have elapsed since the insured person was last confined in a skilled nursing facility.

Prescription Drug Benefits

What is covered

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

- Drugs that by Federal law of the United States require a doctor's prescription for their purchase
- Insulin
- Needles and syringes for the administration of covered medications

What is not covered

- Drugs and devices used for contraceptive purposes, including oral contraceptives and implanted drugs, such as Norplant
- Nonprescription medicines (over-the-counter medication)
- Drugs and supplies for cosmetic purposes
- Nutritional supplements and vitamins
- Medication that under Federal law does not require a prescription, even if your doctor prescribes it or State law requires it

From a pharmacy

You may purchase covered drugs and supplies through any retail pharmacy. Benefits are payable under Other Medical Benefits, page 16, and the calendar year deductible applies.

Waiver

When Medicare Part B is the primary payer, the Plan will waive the deductible and coinsurance applicable to covered drugs and supplies.

To claim benefits

Claims for prescription drugs and medicines that are not ordered through the mail order drug program must include receipts that include the name of patient, prescription number, name of drugs and medicines, name of the prescribing doctor, name of pharmacy, date and the charge. Use the Plan's claim form to claim benefits for prescription drugs and supplies you purchased through a retail pharmacy. You may obtain claim forms by calling 202/833-4910. Mail claims to the Plan's address on page 21.

By mail

If your doctor orders more than a 21-day supply of drugs or covered supplies, up to a 90-day supply, you may order your prescription or refill by mail. National Rx Services will fill your prescription. All drugs and supplies listed above are covered except for those that require constant refrigeration, are too heavy to mail, or that must be administered by physicians in a clinical setting.

If a Federally-approved generic equivalent to the prescribed drug is available, National Rx Services will dispense the generic equivalent instead of the name brand unless your doctor specifies that the name brand is required.

You pay an \$8.00 copayment for each prescription drug, supply, or refill you purchase by mail. No deductible applies.

Waiver

When Medicare Part B is the primary payer, your copayment is waived after you supply proof of your enrollment in Part B directly to National Rx Services.

To claim benefits

The Plan will send you information on National Rx Services. To order by mail:

- 1) Complete the initial mail order form;
- 2) Enclose your prescription and copayment;
- 3) Mail your order to National Rx Services; and
- 4) Allow approximately two weeks for delivery.

You'll receive forms for refills and future prescription orders each time you receive drugs or supplies under this program. In the meantime, if you have any questions about a particular drug or a prescription, and to request your first order forms, you may call toll-free: 1-800/631-7780.

Drugs from other sources

Prescription drugs are also covered under this Plan when they are provided to you by a doctor or facility.

Dental Benefits

What is covered

The Plan will pay **100%** of charges of a dentist (D.D.S. or D.M.D.) up to the amounts shown for the following dental services. The Plan will pay dental benefits for the listed procedures only.

Dental care

Preventive care, limited to two services per person per calendar year

- Oral exam \$13
- Prophylaxis (cleaning), adult 23
- Prophylaxis, child (thru age 14) 16
- Prophylaxis with fluoride, child (thru age 14).....26

Surgery

- Apicoectomy (tooth root amputation) \$50
- Alveolectomy (excision of alveolar bone)
 - 4 through 12 teeth 40
 - 13 through 20 teeth 60
 - 21 or more teeth 80
- Alveolar abscess, incision and drainage 10
- Gingivectomy (excision of gum tissue)
 - each quadrant 50

Orthodontic services

Plan pays **50%** of reasonable and customary charges for orthodontic services up to \$1,000 per person in a lifetime. Orthodontics, for purposes of this benefit, is the realignment of natural teeth or correction of malocclusion.

A new enrollee in this Plan is not eligible for this benefit until 12 months of continuous enrollment have elapsed.

Related benefits

Oral surgery

For covered oral surgery, including the removal of impacted teeth, see page 13.

Accidental injury to sound, natural teeth

Dental work required due to accidental injury to sound natural teeth is covered as described under Other Medical Benefits if performed within 24 months of the accident and the member was covered by this Plan when the accident occurred (see page 16).

What is not covered

- Other dental services, including dental implants, not listed as covered
- Any other expenses for covered dental services (except as shown above, and except for hospitalization when required) are not covered under any other provision of this Plan
- Treatment of temporomandibular joint (TMJ) disorders (except as provided on page 13 under Oral and maxillofacial surgery)

How to Claim Benefits

Claim forms and identification cards

If you do not receive your identification card(s) within 60 days after the effective date of your enrollment you may call the Carrier at 202/833-4910 to report the delay. In the meantime use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services. This is also the number to call for claim forms or advice on filing claims.

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

How to file claims

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

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

In addition:

- A copy of the explanation of benefits (EOB) from any primary payer must be sent with your claim. See page 27 for Medicare claims.
- Bills for private duty nurses must show that the nurse is a registered or licensed practical nurse and include initial history and physical, treatment plan indicating expected duration and frequency from the attending physician and nursing notes from the provider of service.
- Claims for rental or purchase of durable medical equipment require the purchase price and a prescription and statement of medical necessity including a diagnosis and estimated length of time needed.
- Claims for physical and speech therapy require an initial evaluation and treatment plan indicating length of time needed and progress (therapy) notes for each date of service from the therapist.
- Claims for overseas (foreign) services — Enrollees serving overseas who are covered by both this Plan and the Medical and Health Program of the Department of State should submit claims to this Plan as described above, or as directed by the Office of Medical Services, through your Administrative Office. Claims may include an English translation. The Plan will translate claims and will convert to U.S. currency using the exchange rate applicable at the time the expense was incurred if no translation or conversion is supplied by the member.
- For dental claims, complete the front side of the Plan's standard claim form and attach a copy of the dentist's itemized bill. The dentist's bill must include the name of the patient, dates of service, itemized charges and the dentist's Federal Tax I.D. number. The Plan no longer has separate dental claim forms.
- For prescription drug claims, see page 19.

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

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

American Foreign Service Protective Association
1716 N Street, NW
Washington, DC 20036-2902

Carrier telephone number:
202 / 833-4910

or in care of Department of State, Washington, DC 20520

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 provide you with a record of expenses submitted and benefits paid for each claim that you file (explanation of benefits). It is your responsibility to keep these payment records. The Carrier will not provide duplicate copies or year end summaries.

How to Claim Benefits *continued*

Submit claims promptly

Claims must be filed within 90 days after the expense for which the claim being made was incurred. The Plan is not required to honor a claim submitted after the 90-day period, and in no event later than 2 years from the date the expense in question 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 the possibility of denial, submit your claims within the 90-day period.

Direct payment to hospital or provider of care

If you wish to authorize direct payment to a hospital, complete an assignment form which will be available at the hospital. The hospital will bill the Plan but you must also complete and forward a claim form with the physician's statement.

When more information is needed

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

Confidentiality

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

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 letter advising you 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.

How to Claim Benefits *continued*

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 should 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 records, explanation of benefit (EOB) forms); and
- Your daytime phone number.

Medical documentation 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.

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 OPM when it rendered its decision affirming the Carrier'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 Carrier to determine if the Carrier has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Carrier in support of OPM's decision on the disputed claim.

Protection Against Catastrophic Costs

Catastrophic protection

For those services with coinsurance, the Plan pays 100% of reasonable and customary charges for the remainder of the calendar year after the calendar year deductible is met, if out-of-pocket expenses for the coinsurance and deductibles in that calendar year exceed \$2,000 for you and any covered family members.

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

- The 10% you pay for inpatient surgery;
- The 20% you pay for hospital charges other than room and board and the \$175 hospital admission deductible;
- The 20% you pay for services and the \$200 calendar year deductible under Other Medical Benefits; and
- The 20% you pay for the daily charges of a skilled nursing facility for up to 30 days.

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

- Expenses in excess of reasonable and customary charges or maximum benefit limitations;
- Expenses for mental conditions, substance abuse, or dental care;
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 25 and 26); and
- Charges in excess of specific Plan allowances, or for services that exceed the number allowed.

Mental Conditions Benefit

If your out-of-pocket expenses for treatment of covered mental conditions exceed \$4,000 in a calendar year for you and any covered family members, the Plan will, for the remainder of the calendar year, pay 100% of reasonable and customary covered charges, subject to benefit maximums, where provided (see page 15).

The following expenses are included under the Mental conditions catastrophic protection benefit:

- The 20% you pay after the first 30 days of an inpatient confinement;
- The 20% you pay for doctors in-hospital visits, limited to a maximum covered out-of-pocket expense of \$10 per visit and 50 visits per calendar year;
- The 25% you pay for outpatient visits, limited to 60 visits per year;
- The 25% you pay for day care, limited to 20 visits per year;
- The 50% you pay for outpatient group therapy, limited to a maximum covered out-of-pocket expense of \$25 per session; and
- The \$200 calendar year deductible.

Expenses not included under the Mental conditions catastrophic protection benefit are:

- The amount you pay for failure to comply with the Plan's precertification requirement;
- Charges in excess of specific Plan allowances, or for services that exceed the number allowed;
- Expenses in excess of reasonable and customary; and
- Expenses for treatment of substance abuse (see page 15).

Carryover

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

Other Information

Precertification

Precertification

Precertify before hospital, skilled nursing facility or hospice admissions; or receiving home health care.

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.

The Plan also requires precertification for home health care, hospice care, and skilled nursing facility care. In order to receive full Plan benefits, you must precertify these services before they are rendered. Please refer to page 18 for more information.

To precertify a planned admission, home health care, hospice care, or skilled nursing facility care:

- You, your representative, your doctor, hospital, home health agency, hospice, or skilled nursing facility must call Mutual of Omaha's Care Review Unit prior to the admission or care. The toll-free number is 1-800/228-0286.
- Provide the following information: enrollee's name and Plan identification number; patient's name, birth date and phone number; reason for hospitalization, proposed treatment; name of hospital, facility or home health agency; name and phone number of admitting doctor; and number of planned days of confinement or care.

For hospital confinements, when the above requirements are met, the Care Review Unit will tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition.

For home health care, hospice care or skilled nursing facility care, when the above requirements are met, the Care Review Unit will notify the patient, the doctor, and the facility or agency that the care is, or is not, certified as medically necessary.

Written confirmation of the Carrier's certification decision will be sent to you, your doctor, and the hospital. If the length of stay or care needs to be extended, follow the procedure 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 Plan will not pay for charges incurred on any extra days that are determined to be not 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 page 26). Precertification is required, however, when Medicare hospital benefits are exhausted prior to using lifetime reserve days.
- You are confined in a hospital outside the 50 United States.

Maternity or emergency admissions

When there is an unscheduled maternity admission, or an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone 1-800/228-0286 within two business days following the day of admission, even if the patient has been discharged from the hospital. Otherwise, inpatient benefits otherwise payable 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 day of the mother's discharge.

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 or treatment was precertified and then provide benefits according to all of the terms of this brochure.

Precertification *continued*

If you do not precertify

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

If the claim review determines that the hospital 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 hospital admission precertified. If the claim review determines that the home health care, hospice care or skilled nursing facility admission was medically necessary, benefits will be reduced as stated on page 18.

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

This Plan and Medicare

Coordinating benefits

The following information applies only to enrollees and covered family members who are entitled to benefits from both this Plan and Medicare. You must disclose information about Medicare coverage, including your enrollment in a Medicare prepaid plan, to this Carrier; this applies whether or not you file a claim under Medicare. You must also give this Carrier authorization to obtain information about benefits or services denied or paid by Medicare when they request it. It is also important that you inform the Carrier about other coverage you may have as this coverage may affect the primary/secondary status of the Plan and Medicare (see page 8).

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

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

This Plan is primary if:

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

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

Medicare is primary if:

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

This Plan and Medicare *continued*

- 8) The patient (you or a covered family member) has completed the 18-month ESRD coordination period and is still eligible for Medicare due to ESRD; or
- 9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payer status for the patient under rules 1) through 7) above.

When Medicare is primary

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

Inpatient Hospital Benefits: If you are enrolled in Medicare Part A, the inpatient hospital precertification requirement is waived, and the Plan will waive the deductible and coinsurance.

Surgical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the coinsurance applicable to surgical care.

Mental Conditions/Substance Abuse Benefits: If you are enrolled in Medicare Part A, the inpatient hospital precertification requirement is waived, and the coinsurance will be waived. If you are enrolled in Medicare Part B, the outpatient deductible and coinsurance will be waived. Visit limitations and the lifetime maximum still apply.

Other Medical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance applicable to medical care and prescription drugs.

Additional Benefits: If you are enrolled in Medicare Part A, the Plan will waive coinsurance applicable to skilled nursing care.

Prescription Drugs: If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance applicable to prescription drugs. If you are enrolled in Part B, the Plan will waive the mail order drug copayment.

Dental Benefits: The coinsurance applicable to dental care is not waived.

When Medicare is the primary payer, this Plan will pay the lesser of (1) its benefits in full, or (2) a reduced amount that, when added to the benefits payable by Medicare, will not exceed 100% of reasonable and customary expenses or, for doctor services, the amount specified by Medicare as described below.

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.

Medicare-participating doctors accept assignment; that is, they have agreed not to bill you for more than the Medicare-approved amount for covered services. Some non-Medicare-participating doctors 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 in those instances where the Medicare and Plan payments combined do not total the Medicare-approved amount.

Non-Medicare-participating doctors do not need to accept assignment. When they do not accept assignment on a claim, they can bill you for more than the Medicare-approved amount — up to a limit set by the Medicare law (the Social Security Act, title 42 U.S.C.) called the limiting charge. The limiting charge is 115 percent of the Medicare-approved amount. 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 set by the Medicare law for non-Medicare-participating doctors. Neither you nor your FEHB Plan is liable for any amount in excess of the Medicare limiting charge for charges of a non-participating Medicare doctor. The Medicare explanation of benefits (EOB) form will have more information about this limit.

How to claim benefits

In most cases, when services are covered by both Medicare and this Plan, Medicare is the primary payer if you are an annuitant and this Plan is the primary payer if you are an employee. When Medicare is the primary payer, your claims should first be submitted to Medicare. The Carrier has contracted with all 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 Carrier. You may call the Carrier at 202/833-4910 to find out if your claims are being electronically filed. If they are not, you should initially submit your claims to Medicare. After Medicare has paid its benefits, the Carrier will consider the balance of any covered expenses. To be sure your claims are processed by this Carrier, you must submit the EOB form from Medicare and duplicates of all bills along with a completed claim form. The Carrier will not process your claim without knowing whether you have Medicare and, if you do, without receiving the Medicare EOB.

Enrollment Information

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Carrier. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Carrier. See “*How to claim benefits*” on page 21.

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 your 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 31). Coverage under your new plan for a hospitalized member may be delayed if you are currently enrolled in another FEHB plan and you or a covered family member are hospitalized on the effective date of your enrollment; see *If you are hospitalized* below.

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

If you are hospitalized

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

Your responsibility

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

Things to keep in mind

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

Enrollment Information *continued*

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 27 for how this Plan's benefits are affected when you are enrolled in a Medicare prepaid plan.

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

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

Coverage after enrollment ends

When an employee'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 31-day free extension of coverage. The employee or family member also may be eligible for one of the following:

Former spouse coverage

When the spouse of 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) may also 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.

Enrollment Information *continued*

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

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

Conversion to individual coverage

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

Definitions

Accidental injury

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

Admission

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

Assignment

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

Calendar year

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

Definitions *continued*

Confinement

An admission (or series of admissions separated by less than 60 days) to a hospital as an inpatient for any one illness or injury. There is a new confinement when an admission is: (1) for a cause entirely unrelated to the cause for the previous admission; (2) for an enrolled employee who returns to work for at least one day before the next admission; or (3) for a dependent or annuitant when confinements are separated by at least 60 days.

Congenital anomaly

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

Cosmetic surgery

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

Custodial care

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

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

The Carrier determines which services are custodial care.

Durable medical equipment

Equipment and supplies that:

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

Effective date

The date the benefits described in this brochure are effective:

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

Expense

The cost incurred for a covered service or supply ordered or prescribed by a doctor. An expense is incurred on the date the service or supply is received. Expense does not include any charge:

- 1) for a service or supply that is not medically necessary; or
- 2) that is in excess of the reasonable and customary charge for the service or supply.

Experimental or investigational drug, device and medical treatment or procedure

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

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

Definitions *continued*

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

Group health coverage

Health care coverage that a member is eligible for because of employment, 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.

Home health care

A plan of continued care and treatment of an insured person who is under the care of a doctor, and whose doctor certifies that without home health care, confinement in a hospital or skilled nursing care facility would be required. Home health care must be provided by a public agency or private organization that is licensed as a home health agency by the State and is certified as such under Medicare.

Hospice care program

A coordinated program of home and inpatient pain control and supportive care for the terminally ill patient and the patient's family, provided by a medically supervised team under the direction of an independent hospice administration approved by the Carrier.

Medically necessary

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

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

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

Mental conditions/ substance abuse

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

Morbid obesity

A condition in which an individual: (1) is the greater of 100 pounds or 100% over the standard weight as determined by the Carrier, with complicating medical condition(s); and (2) has been so for at least five years, despite documented unsuccessful attempts to reduce under a doctor-monitored diet and exercise program.

Prosthetic appliance

A device which is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body. Prosthetic appliances include such items as artificial legs, artificial hips, artificial knees, intraocular lenses and pacemakers.

Reasonable and customary

Those charges that are comparable to charges made by other providers for similar services and supplies under comparable circumstances in the same geographic area. The Carrier's allowances are developed from actual claims received in each Zip Code area throughout the United States, as compiled by the Health Insurance Association of America, and are updated twice a year, at the 90th percentile. This method is used for determining reasonable and customary allowances for surgery, maternity, doctor and other professional services, Other Medical and Mental Conditions/ Substance Abuse Benefits, and accidental injury care. For other categories of benefits, and for certain specific services within each of the above categories, exceptions to this general method for determining the Carrier's allowances may exist.

Sound natural tooth

A tooth which is whole or properly restored and is without impairment, periodontal or other conditions and is not in need of the treatment provided for any reason other than an accidental injury.

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(This Index references both covered and non-covered services and supplies.)

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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, but are made available to all enrollees and family members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles, out-of-pocket maximum, copay charges, etc. These benefits are not subject to the FEHB disputed claims review procedure.

Long Term Care

Long Term Care is open to AFSPA members under the age of 80. Premium rates are based on your age at the time of acceptance into the program. The program:

- Covers confinements for skilled nursing, intermediate nursing and custodial care (\$100 per day benefit).
- Covers confinement in an Assisted Living Facility (\$50 per day benefit).
- Covers nonconfinement care for home health care, adult day care and respite care (\$50 per day benefit).
- Contains return of premium feature.
- Contains benefit increase option.
- Contains optional automatic inflation protection rider.

Term Life Insurance

Term Life Insurance is open to all AFSPA members until age 60. The program includes:

- Up to \$200,000 of coverage.
- Living Care Benefit that allows early access in certain cases to a portion of your life insurance benefits.
- Coverage for deaths **including acts of terrorism or declared or undeclared war.**

Expanded Dental Benefits

Expanded Dental benefit programs are open to every AFSPA member. We offer two different plans: one that is available in the DC metropolitan area; and one that is available overseas and anywhere in the U.S. The plans cover services such as fillings, X-rays, crowns, root canals and preventive care. Premiums are based on self-only, two party, or family enrollment, and may be paid quarterly or annually.

- CONSUMER DENTAL CARE (Available DC/MD/VA Only)
 - No claim forms
 - No deductibles
 - No limitations or lifetime maximum
 - No waiting periods for pre-existing conditions
- THE DENTAL INDEMNITY PLAN (Available overseas and anywhere in the U.S.)
 - \$1,000 maximum allowance per year
 - Annual deductible (\$50 per individual/\$150 per family)
 - No deductible for preventive care

Senior Living Services

AFSPA has a broad program for senior living alternatives. At no additional cost to our members we offer information on senior living facilities throughout the U.S., including preferred access at certain locations.

Legal Services

Legal services are available through arrangements with four firms in the Washington Metropolitan area. Most areas of law are practiced. Members of AFSPA are offered special rates.

Travel Assistance Services

AFSPA, in conjunction with Worldwide Assistance Services, Inc., offers a valuable product called Travel Assistance International (TAI). TAI has local representatives in practically every country in the world and can provide you with:

- Unlimited emergency medical evacuation to the nearest medical facility where you can receive treatment.
- On the spot medical payments. If you become injured or sick overseas, payment can be made instantly to the medical provider. Your only out-of-pocket expense is a standard \$100.00 deductible.
- Worldwide medical referrals and medical monitoring.
- Prescription replacement assistance.
- Repatriation of remains benefit.

For more information on this service only please call 1/800/821-2828 and identify yourself as a member of AFSPA to receive special reduced member rates.

For information and written material on any of the above programs, please contact us at:

American Foreign Service Protective Association
1716 N Street, NW
Washington, DC 20036-2902
202/833-4910 E-mail: afspa@afspa.org
202/833-4918 (fax) Web page: www.afspa.org

Benefits on this page are not part of the FEHB Contract

How the Foreign Service Benefit Plan Changes January 1997

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

Benefit changes • The mail order prescription copayment has been changed from \$5.00 to \$8.00.

Clarifications

- The use of a Plan identification card to obtain benefits after you are no longer enrolled in the Plan is a fraudulent action subject to review by the Inspector General.
- Medical data that does not identify individual members may be disclosed as a result of bona fide medical research or education.
- **General Information** — When a family member is hospitalized on the effective date of an enrollment change and continues to receive benefits under the old plan, benefits under the new plan will begin for other family members on the effective date of the new enrollment.
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.
Annuitants and former spouses with FEHB coverage, and who are covered by Medicare Part B, may join a Medicare prepaid plan if they do not have Medicare Part A, but they will probably have to pay for hospital coverage. They may also remain enrolled under an FEHB plan when they enroll in 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).
Temporary continuation of coverage (TCC) for employees or family members who lose eligibility for FEHB coverage includes one free 31-day extension of coverage and may include a second. How these are coordinated has been clarified; notification and election requirements have also been clarified.
“Conversion to individual coverage” does not require evidence of good health and the Plan is not permitted to impose a waiting period or limit coverage for preexisting conditions; benefits and rates under the individual contract may differ from those under the FEHB Program.
- The rules concerning whether this Plan or Medicare pays your claim first when you are entitled to benefits under both this Plan and Medicare have been clarified.
 - This Plan is primary if you, the enrollee, are age 65 or over, have Medicare, and are employed by the Federal Government. If your covered spouse is age 65 or over, has Medicare, and is employed by the Federal Government and you, the enrollee, are not, Medicare is primary.
 - Medicare is primary if 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.
- Specified outpatient diagnostic and surgical procedures no longer require precertification of medical necessity.
- Benefits for routine circumcision have been clarified to indicate coverage for a newborn child.
- The Plan has removed oxygen equipment from an example of durable medical equipment and placed it with oxygen.

Other changes

- The section on how to become a member of the American Foreign Service Protective Association has been changed to allow membership to other Executive Branch civilian employees assigned overseas with medical clearance from the Department of State or the Department of Defense.
- The “Flexible services option” is now known as the “Flexible benefits option.”
- Enrollees who change their FEHB enrollments using Employee Express may call the Employee Express HELP number to obtain a letter confirming that change if their ID cards do not arrive by the effective date of the enrollment change.
- **If you are eligible for Medicare**, the information about Medicare coverage that you must disclose to the Carrier now includes your enrollment in a Medicare prepaid plan.
- When you are enrolled in both this Plan and a Medicare prepaid plan, this Plan will not waive any deductible or coinsurance.
- The fact that an enrollee does not have a vested right to receive the benefits in this brochure in 1998 or later years, nor to benefits for years prior to 1997 unless those benefits are in this brochure, is now stated under “General Limitations” as well as on page 2.
- 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 Programs (OWCP) to be payable under workers’ compensation or by a similar agency under another Federal or State law. The Carrier is entitled to be reimbursed by OWCP (or the similar agency) for services it paid that were later found to be payable to OWCP (or the agency).
- **Disputed claims** — If your claim for payment or services is denied by the Carrier, and you decide to ask OPM to review that denial, you must first ask the Carrier to reconsider their decision. You must now request their reconsideration within six months of the denial (previously, you had one year to do this). 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.
Providers, legal counsel, and other interested parties may act as your representative in pursuing payment of a disputed claim only with your written consent. Any lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan must be brought against the Office of Personnel Management in Federal court and only after you have exhausted the OPM review procedure.

Summary of Benefits for the Foreign Service Benefit Plan – 1997

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 \$200 calendar year deductible.

Benefits	Plan pays/provides	Page
Inpatient care	Hospital After the \$175 inpatient hospital deductible per person per confinement, the Plan pays 100% of semiprivate room and board charges plus 80% of reasonable and customary charges for other hospital services and supplies	11
	Surgical 90% of reasonable and customary charges	12, 13
	Medical 80% of reasonable and customary charges	11
	Maternity Same benefits as for illness and injury	14
	Mental Conditions 100% of all covered charges for the first 30 days, then 80% of all covered charges	15
	Substance Abuse 100% of charges up to \$8,000 for one 28-day inpatient treatment program per calendar year; detoxification — 5 days confinement per calendar year.	15
Outpatient care	Hospital 100% of covered services and supplies related to and rendered within 72 hours of surgery; 80%* of reasonable and customary charges for outpatient services and supplies	12, 13, 14, 15, 16, 17, 18, 20
	Surgical 100% of reasonable and customary charges	12, 13
	Medical 80%* of reasonable and customary charges	16
	Maternity Same benefits as for illness or injury	14
	Home Health Care Precertified and non-precertified benefits are payable. Refer to Additional Benefits	18
	Mental Conditions 75%* of reasonable and customary charges for individual therapy (limited to 60 visits per person per year) and for day care visits (limited to 20 visits per person per year); 50%* of reasonable and customary charges up to \$25 per session for group therapy	15
Substance Abuse Aftercare treatment program immediately following inpatient confinement is paid as part of the inpatient substance abuse benefit	15	
Emergency care (accidental injury)	100% of reasonable and customary charges for outpatient hospital and physicians' charges rendered within 72 hours after an accidental injury. Other emergency services are covered the same as non-emergency services	18
Prescription drugs	80%* of reasonable and customary charges for drugs from a pharmacy	16, 19
	You pay \$8 per prescription for up to a 90-day supply of medication ordered and supplied by mail	19
Dental care	Routine preventive care and surgical procedures up to amounts shown. Orthodontics up to \$1,000 per person per lifetime, at 50% of reasonable and customary charges	20
Additional benefits	Hospice care, home health care, private duty nursing at home, childhood immunizations, renal dialysis, skilled nursing facilities, emergency ambulance service	18
Protection against catastrophic costs		
Medical/Surgical	When out-of-pocket expenses exceed \$2,000 in a calendar year for you and your family the Plan pays 100% of reasonable and customary covered charges for the remainder of that year	24
Mental Conditions	When out-of-pocket expenses exceed \$4,000 in a calendar year for you and your family the Plan pays 100% of reasonable and customary covered charges for the remainder of that year subject to benefit maximums	24

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**United States
Office of
Personnel
Management**



1997 Rate Information for Foreign Service Benefit Plan

FEHB benefits of this Plan are described in brochure RI 72-1.

The 1997 rates for this Plan follow. If you are in a special enrollment category, refer to an FEHB Guide or contact the agency that maintains your health benefits enrollment.

Type of Enrollment	Code	<u>Premium</u>			
		<u>Biweekly</u>		<u>Monthly</u>	
		Gov't Share	Your Share	Gov't Share	Your Share
Self Only	401	62.83	25.04	136.13	54.26
Self and Family	402	134.94	78.72	292.37	170.56