

NYLCare Health Plans of the Mid-Atlantic 1997  
(Formerly HealthPlus)

A Prepaid Comprehensive Medical Plan

**This plan has full accreditation  
from the NCQA. See the FEHB Guide  
for more information on NCQA.**

Serving:

Washington, DC, Baltimore, MD and Fredericksburg/Richmond/Tri-cities, VA  
metro areas

Enrollment code:

- JN1 High Option Self Only
- JN2 High Option Self and Family
- JN4 Standard Option Self Only
- JN5 Standard Option Self and Family

Service Area:

Services from Plan providers are available only in the following area:

All of Washington, DC; the Maryland counties of Anne Arundel, Baltimore, Calvert, Carroll, Charles, Frederick, Harford, Howard, Prince George's, Montgomery and St. Mary's plus the city of Baltimore; the Virginia counties of Amelia, Arlington, Caroline, Charles City, Chesterfield, Dinwiddie, Fairfax, Fauquier, Goochland, Hanover, Henrico, King George, King William, Loudoun, Louisa, New Kent, Nottoway, Powhatan, Prince George, Prince William, Spotsylvania, Stafford, Surry, Sussex, and Westmoreland, plus the cities of Alexandria, Colonial Heights, Fairfax, Falls Church, Fredericksburg, Hopewell, Manassas, Manassas Park, Petersburg and Richmond.

Enrollment Area:

You must live or work in the Service Area to enroll in this Plan. Only emergency services are available from this Plan outside the Service Area.

RI 73-067

NYLCare Health Plans of the Mid-Atlantic, Inc.

NYLCare Health Plans of the Mid-Atlantic, Inc., 7601 Ora Glen Drive, Greenbelt, MD, 20770, has entered into a contract (CS 1884) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called NYLCare Health Plans of the Mid-Atlantic, NYLCare, or the Plan.

This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. A person enrolled in the Plan is entitled to the benefits stated in this brochure. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. If

enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1997, and are shown on the inside back cover of this brochure.

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

- Call the provider and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 301/441-1600 or 800/635-3121 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE  
202/418-3300

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

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

#### General Information

#### Confidentiality

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

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member

information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

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

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on page 14. If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See "If you are hospitalized" on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program except as stated in any cosmetic surgery or dental benefits description in this brochure.

#### General Information continued

#### 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; both parent and child are covered only for care received from Plan providers, except for emergency benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

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

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

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

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

#### Coverage after enrollment ends

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

#### Former spouse coverage

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

#### General Information continued

#### Temporary continuation of coverage (TCC)

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

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

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

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

#### Notification and election requirements

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

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

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

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or

she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

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

### Conversion to individual coverage

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

### Facts about this Plan

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

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

Who provides care to Plan members?

NYLCare Health Plans of the Mid-Atlantic is an individual practice prepayment plan (IPP) offering coordinated services through more than 5,000 private practice doctors, hospitals, and other health care providers. Each member may choose his or her own primary care doctor from the Plan's participating primary care doctors listed in the provider directory. When you choose a primary care physician in an individual practice, you receive covered care from medical specialists (including hospitals) from the entire network of providers. When you choose a primary care physician in a group practice or physicians association, you receive covered care from participating specialists and hospitals associated with that group or physician association. If you need covered care that is not available from providers affiliated with your group practice or physicians' association, the Plan will make arrangements for your care. Members must also select one family dentist for the entire family.

### Role of a primary care doctor

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when there has been a referral by the member's primary care doctor, with the following exceptions: a woman may see her Plan gynecologist directly for a well woman exam every 12 months with no need to be referred by her primary care doctor. She may also see her Plan gynecologist for certain gynecological care without a referral from her primary care doctor. See the "limited benefits" section of "Medical and Surgical Care" on page 12 for further details. Members may also see their Plan dentist for covered dental care, and their optometrist for covered vision care without a referral. Finally, referrals are also not necessary for pre and post natal office visits after the initial visit.

### Choosing your doctor

The Plan's provider directory lists primary care doctors (family and general practitioners, pediatricians, and internists), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated and are available at the time of enrollment or upon request by calling the Customer Services Department at 301/441-1600 or 800/635-3121; you can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed.

If you enroll you will be asked to complete a primary care doctor selection form and send it directly to the Plan, indicating the name(s) of the primary care doctor(s) you select for you and each member of your family.

Members may change their doctor selection by notifying the Plan 30 days in advance.

If you are receiving services from a doctor who leaves the Plan, the Plan will pay for covered services until the Plan can arrange with you for you to be seen by another participating doctor.

#### Referrals for specialty care

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

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation. All follow-up care must be provided or arranged by the primary care doctor. On referrals, the primary care doctor will give specific instructions to the specialist or consultant as to what services are authorized. If additional services or visits are suggested by the specialist or consultant, you must first check with your primary care doctor. Do not go to the specialist or consultant unless your primary care doctor has made the necessary arrangements and obtained any required Plan authorization for the referral in advance.

#### Authorizations

Your primary care doctor must obtain authorization from the Plan before you may be hospitalized or referred for certain specialty services.

#### For new members

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

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

#### Hospital care

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

## Out-of-pocket maximum

Copayments are required for a few benefits. However, copayments will not be required for the remainder of the calendar year after your out-of-pocket expenses for services provided or arranged by the Plan reach \$650 per Self Only enrollment or \$1,500 per Self and Family enrollment under the High Option or \$1,000 per Self Only enrollment or \$2,500 per Self and Family enrollment under the Standard Option. This copayment maximum does not include costs of dental services, prescription drugs, durable medical equipment, orthopedic devices, inpatient care of mental conditions/substance abuse, or, under High Option, vision care.

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

## Deductible carryover

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

## Facts about this Plan continued

### Submit claims promptly

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

### Other considerations

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

## The Plan's service and enrollment areas

The service area for this Plan, where Plan providers and facilities are located, is the same as the enrollment area listed on the front cover of this brochure (the area in which you must live or work to enroll in the Plan). Benefits for care outside the service area are limited to emergency services, as described on page 15.

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

## General Limitations

### Important notice

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

### Circumstances beyond Plan control

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

### Other sources of benefits

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

### Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, benefits will be coordinated with Medicare according to Medicare's determination of which coverage is primary. Generally, you do not need to take any action after informing the Plan of

your or your family member's eligibility for Medicare. Your Plan will provide you with further instructions if a Medicare claim needs to be filed.

#### General Limitations continued

#### Group health insurance and automobile insurance

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

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan. One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

#### CHAMPUS

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

#### Medicaid

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

#### Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation 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 law. If medical benefits provided under such law are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

#### DVA facilities, DoD facilities, and Indian Health 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 statutes governing such facilities.

#### Other Government agencies

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

#### Liability insurance and third party actions

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

#### General Exclusions

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

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see Emergency Benefits);
- Expenses incurred while not covered by this Plan;

- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs or devices that are experimental or investigational;
- Procedures, services, drugs and supplies related to sex transformations; and
- Abortions, except when the life of the mother would be endangered if the fetus were carried to term

## Medical and Surgical Benefits

### What is covered

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

High Option—You pay a \$5 office visit copay; but no additional copay for laboratory tests and X-rays. You pay a \$5 house call copay for a doctor's visit, nothing for visits by nurses and health aides. You pay a \$20 copay for doctor visits or house calls after hours.

Standard Option—You pay a \$10 office visit copay; but no additional copay for laboratory tests and X-rays. You pay a \$10 house call copay for a doctor's visit, nothing for visits by nurses and health aides. You pay a \$10 copay for doctor visits or house calls after hours.

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

- Preventive care, including well-baby care and periodic health assessments
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor (office visit copays are waived for obstetrical care after the first maternity care visit). If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of the infant requiring definitive

treatment will be covered only if the infant is covered under a Self and Family enrollment.

- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum); you pay, under High Option, a \$25 copay per visit for allergy testing and a \$5 copay per allergy immunization. Under Standard Option, you pay nothing.
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints. The cost of insulin pumps, and mechanical organ replacements (such as artificial hearts or left ventricular assistance devices) are not covered.
- Cornea, heart, kidney, liver, single lung, double lung, heart/lung, and kidney/pancreas transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; testicular, mediastinal, retroperitoneal and ovarian germ cell tumors; breast cancer; multiple myeloma; and epithelial ovarian cancer when performed at a Plan Center of Excellence. Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan.
- Dialysis
- Surgical treatment of morbid obesity
- Chemotherapy, radiation therapy, and inhalation therapy
- Home health services of skilled nurses and health aides, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you except as noted.

#### Limited benefits

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

## Medical and Surgical Benefits continued

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

Gynecological care that can be provided in the gynecologist's office is available without a referral from the member's primary care doctor. The two exceptions to this are that a woman must continue to have infertility services and outpatient surgical procedures coordinated by her primary care doctor. You pay the appropriate office visit copay.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to a maximum of two months per condition, when a Plan doctor has determined that provision of therapy will result in a significant improvement in the member's condition within two months of the date of the first treatment; you pay a \$5 copay per outpatient session under High Option; you pay nothing under Standard Option. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Diagnosis and treatment of infertility, as well as artificial insemination, are covered; you pay 50% of covered charges under both options. Cost of donor sperm, including preparation and testing is not covered. Fertility drugs (oral or suppository only) are covered at 50% of charges. Other assisted reproductive technology (ART) procedures such as in vitro fertilization and embryo transfer including, but not limited to GIFT and ZIFT, are not covered.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided at a Plan facility for up to a maximum of two (2) months; you pay a \$5 copay per visit under both options.

The rental or purchase of durable medical equipment, such as wheelchairs, and orthopedic devices, such as braces or crutches are covered; you pay 50% coinsurance under both options. The decision of whether the devices or equipment will be rented or purchased rests solely with the Plan. The repair, replacement or duplicates of durable medical equipment or orthopedic devices is not covered.

What is not covered

- Physical examinations or immunizations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary sterilization
- Surgery primarily for cosmetic purposes
- Hearing aids
- Chiropractic services
- Homemaker services
- Transplants not listed as covered
- Prosthetic devices, such as artificial limbs and external lenses following cataract removal
- Blood and blood derivatives
- Long-term rehabilitative therapy
- Acupuncture, naturopathy and hypnotherapy
- Orthotics

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor.

High Option—you pay nothing.

Standard Option—Subject to annual out-of-pocket maximum, you pay a \$200 copay per medical admission; a \$400 copay per surgical or maternity admission; and a \$50 copay per outpatient surgical visit.

All necessary services are covered, including:

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

## Extended care

The Plan provides a comprehensive range of benefits for up to 60 days per member per year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. You pay nothing. All necessary services are covered, including:

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

## Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of six months or less. This benefit is limited to 180 days per member. You pay nothing.

## Ambulance service

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

## Limited benefits

### Inpatient dental procedures

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

### Acute inpatient detoxification

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

## What is not covered

- Personal comfort items, such as telephone, television and personal care kits

- Blood and blood derivatives
- Custodial care, rest cures, domiciliary or convalescent care

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

## Emergency Benefits

What is a medical emergency?

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

## Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

Plan pays...

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

You pay...

A \$20 copay under High Option and a \$15 copay under Standard Option per urgent care center visit; a \$20 copay per visit under High Option for care rendered by a primary care doctor after normal business hours (under Standard Option you pay a \$10 copay); a \$40 copay under High Option and a \$25 copay under Standard Option per emergency room visit for emergency care services which are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency copayment is waived and:

High Option—You pay nothing.

Standard Option—You pay a \$200 copay per medical admission; a \$400 copay per surgical admission.

Emergencies outside the service area

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

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Plan pays...

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

You pay...

A \$20 copay under High Option and a \$15 copay under Standard Option per urgent care center visit; a \$40 copay under High Option and a \$25 copay under Standard Option per emergency room visit for emergency care services which are covered benefits of this Plan. The emergency copayment is waived upon admission and:

High Option—You pay nothing.

Standard Option—You pay a \$200 copay per medical admission; a \$400 copay per surgical admission.

What is covered

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

## What is not covered

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

## Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 20.

## Mental Conditions/Substance Abuse Benefits

### Mental Conditions

## What is covered

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

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

### Outpatient care

Up to 50 outpatient visits to Plan doctors, consultants, or other psychiatric personnel each calendar year; you pay a \$25 copay for each covered visit—all charges thereafter.

## Inpatient care

Up to 30 days of hospitalization each calendar year; you pay \$50 per day for up to 30 days—all charges thereafter.

## What is not covered

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

## Substance Abuse

### What is covered

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

## Prescription Drug Benefits

### What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. A generic drug will be provided when substitution is permissible and a name brand is not specified by your doctor. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Non-formulary drugs may be dispensed when prescribed by a Plan doctor and approved in advance by the Plan. Under High Option there is no deductible, you pay a \$4 copay for generic drugs or a \$8 copay for name brand drugs per prescription unit or refill; under Standard Option you pay the first \$75 per person of covered benefits each calendar year, then you pay a \$4 copay for generic drugs or a \$8 copay for name brand drugs per prescription unit or refill.

When generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug),

but you request the name brand drug, you pay the price difference between the generic and name brand drug as well as the \$4 generic drug copay per prescription unit or refill.

You can also obtain prescription drugs by mail through the Home Delivery Pharmacy Service. You pay a \$8 copay for generic or name brand drugs for up to a 90-day supply per prescription unit or refill. Prescription drugs purchased through the Home Delivery Pharmacy Service are not subject to the \$75 Standard Option calendar year deductible. Contact the Plan at (301) 441-1600 for information on filing claims and the Home Delivery Pharmacy Service.

In the case of a medical emergency outside of the Plan's service area when drugs are purchased from a non-participating provider, the Plan will provide reimbursement for up to a 10-day supply per prescription. You pay the applicable copay or drug deductible.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Oral contraceptive drugs and devices that require a prescription
- Insulin
- Disposable needles and syringes needed to inject covered prescribed medication, including insulin
- Intravenous fluids and medications for home use, when obtained through the Plan's home health service benefit
- Fertility drugs (oral and suppository only) are covered under the Plan's benefit for the treatment of infertility on page 12xx at 50% of charges.

What is not covered

- Drugs available without a prescription or for which there is a non-prescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Smoking cessation drugs and medications, including nicotine patches and nicotine gum
- Appetite suppressants
- Implanted time-release medications, such as Norplant

- Diabetic supplies (except for test strips and lancets)
- Injectable contraceptive drugs
- Injectables (except insulin), aerosol inhalers and inhalant solutions except when obtained through the Home Delivery Pharmacy Service.
- Topical fluoride preparations

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

#### Other Benefits

#### Vision care - High Option only

#### What is covered

In addition to the Medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, the Plan covers the following vision care benefits when obtained from a Plan optometrist; eye refractions (eye examinations for eye glass prescription) eyeglasses and contact lens services, which include an eye exam and contact lens fitting, the actual lenses and follow-up care. Contact lens prescriptions are not dispensed separately. They are included in the contact lens service. You pay the copays listed below:

Benefit	You Pay
Exams and frames	
Eye examination	\$25
Standard frames	\$19.50
Premium frames	\$24.50
Elite frames	\$ 29.50
Lenses (per pair)	
Single vision	\$20
Bifocal	\$40
Trifocal	\$50
Lenticular	\$72
Progressive	\$85
Contact lens services (per pair)	
(Benefit includes examination, one (1) pair of contact lenses and follow-up care for three (3) months)	
Standard lenses	
Daily wear hard and soft	\$ 90
Extended wear soft	\$110
Gas permeable	\$110
Gas permeable extended wear	\$120
Toric	\$200
Premium lenses	
Daily wear hard and soft	\$100
Extended wear soft	\$120
Opaque soft extended wear lenses	\$185

Disposables (4) 6 packs per pair	\$160
Replacement contact lenses (per pair)	
Standard lenses	
Daily wear hard and soft	\$47
Extended wear soft	\$72
Gas permeable	\$72
Gas permeable extended wear	\$92
Toric	\$132
Premium lenses	
Daily wear hard and soft	\$62
Extended wear soft	\$101
Opaque soft extended wear lenses	\$126
Disposables (4) 6 packs per pair	\$ 86
Additional follow-up visits	\$ 15 per visit (after three (3) months)

What is not covered

- Eye exercises

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Other Benefits (continued)

Dental care

What is covered

The following partial list summarizes the dental services provided by participating Plan dentists and indicates copays where they apply. Please check with the Plan for details. Unlisted procedures are provided at a 20% discount. All services are to be paid for at the time they are rendered.

Benefit enrollees)	You Pay: Blue Plan (for High Option option enrollees)	Green Plan (for Standard
Preventive Dentistry		
Clinical exam/treatment plan	Nothing	Nothing
Oral cancer examination	Nothing	Nothing
Fluoride treatments	Nothing	Nothing
Oral hygiene instruction	Nothing	Nothing
Dental health education	Nothing	Nothing
Visual aids	Nothing	Nothing
Study models	Nothing	Nothing
Consultations	Nothing	Nothing
Periodontal examination (by general dentist)	Nothing	Nothing
Prophylaxis (cleaning every six months)	\$10	\$15-Child \$20-Adult

Bitewings or periapical X-ray (per film)	\$5	\$6
Full mouth or panorex X-rays	\$20	\$30
Fillings		
Silver 1 surface	\$28	\$35
2 surfaces	\$34	\$45
3 surfaces or more	\$40	\$55
Composite resin (white) 1 surface	\$28	\$45
2 surfaces	\$34	\$55
3 surfaces or more	\$40	\$65
Sedative fillings	\$10	\$20
Temporary fillings	\$10	\$20
Pulp cap (direct or indirect)	\$5	\$10

Services provided by a pediatric dentist (children & adolescents only) are covered at a 20% reduction of UCR.

Emergency dental visits	\$20	\$30
Repairs		
Full denture repairs (no teeth) (office only)	\$18	\$35
Partial denture repairs (no teeth) (office only)	\$18	\$35
Extractions (as performed by a participating general dentist)		
Permanent or Primary-simple	\$25	\$35
Root canal therapy (as performed by a participating general dentist)		
anterior	\$160	\$225
bicuspid	\$195	\$290
molar	\$265	\$375
Pulpotomy (not root canal) removal of nerve tissue on primary teeth	\$60	\$60
Full denture (Upper or lower)	\$355	\$495
Partial denture (Upper or lower) regardless of the number of teeth needed to be replaced	\$380	\$560
Reline of dentures (ADA approved materials only)		
Office	\$110	\$115
Laboratory	\$135	\$180
Denture repairs (Laboratory)		
No teeth involved	\$80	\$80
Each tooth add	\$10	\$10
Broken appointments (less than 24-hour notice) per 1/2 hour	\$15	\$15
Crown and Bridge (per unit)		
Porcelain veneer crown	\$295	\$430
Full cast crown	\$285	\$405
Porcelain laminate veneer	\$275	\$330
Recement crown/bridge	\$30	\$30
Crown buildup/post & core	\$90	\$105
Maryland bridge (per unit)	\$135	\$185
Acid etch bonding (involving incisal angle)	\$ 80	\$ 85
Cosmetic bonding (with composite)	\$ 110	\$ 115
Filling pin reinforced (in addition to the cost of the filling)		
Silver	\$35	\$35
Composite	\$35	\$35
Stainless Steel crown	\$85	\$95

Night guard		
Hard or soft	\$155	\$190
Sealants	\$15	\$15
Oral surgery		
Simple extraction, single tooth	\$42	\$42
Surgical extraction of erupted tooth	\$58	\$58
Extraction, soft tissue impaction	\$78	\$78
Extraction, partial bony impaction	\$105	\$105
Extraction, full bony	\$130	\$130
General anesthesia (per 1/2 hour)	\$80	\$80
Nitrous oxide sedation (per 1/2 hour)	\$15	\$15
Panorex by oral surgeon	\$35	\$35
Consultation by oral surgeon	\$ 35	\$ 35
Local anesthesia	Nothing	Nothing
Oral surgery procedures in the hospital	UCR	UCR
Patient will be liable for hospital costs in the event oral surgery is performed in the hospital		
Root canal therapy (as performed by an endodontist only)		
anterior	\$335	\$335
bicuspid	\$440	\$440
molar	\$520	\$520
Consultation by endodontist	\$ 35	\$ 35
Periodontics (Gum treatment Per Quadrant)		
Surgical services (includes customary post-surgical services)		
Gingival curettage	\$130	\$130
Gingivectomy or gingivoplasty	\$150	\$150
Osseous surgery (including flap entry and closure)	\$525	\$525
Free soft tissue grafts (including donor site)	\$350	\$350
Adjunctive services		
Periodontal scaling and root planing, per quadrant	\$95	\$95
Periodontal consult by periodontist	\$90	\$90
Bite guard (by periodontist)	\$220	\$220
Periodontal maint. visit including periodic oral exam	\$70	\$70
Orthodontics		
Initial consultation	Nothing	Nothing
Diagnostic records, X-rays and consultation fees	\$120	\$120
Balance of orthodontic treatment for standard	\$2040 <sup>1</sup>	\$2040 <sup>1</sup>

2 year-case including retention beyond 2 years  
(For children under age 18)

Minor treatment for tooth guidances and space management therapy is provided at a 20% reduction of UCR.

Adult orthodontic treatment (for patients age 18 and over) is provided at a 20% reduction of UCR.

All orthodontic treatment plans that are not a standard 2-year case are pro-rated at \$80.00 per month.

Orthodontic treatment already in progress is not covered under the program.

All gold is charged at market price.

1Three hundred dollars (\$300) is payable in advance of treatment. The balance is to be paid in monthly installments. Subscriber/dependent will be given a coupon book with stubs for each monthly payment to be made to the personal participating dentist or approved specialist. For treatment plans other than two years, a pro-rated member fee will be used.

#### Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. You must seek treatment within 72 hours after the accidental injury. Injuries caused by biting and chewing are not covered.

You pay copay based on your enrollment option and where the care is received (office visit, emergency room, etc.).

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

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

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

Benefits on this page are not part of the FEHB contract

#### How to Obtain Benefits

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Customer Services Office at 301/441-1600 or 800/635-3121 or TDD 301/441-4535 or 800/522-7128 or you may write to the Plan at 7601 Ora Glen Drive, Greenbelt, MD 20770.

#### Questions

#### Disputed claims review

#### Plan reconsideration

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

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

#### OPM review

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

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

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

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

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

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);

- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and
- Your daytime phone number.

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

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 4, 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 Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

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

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

How NYLCare Health Plans of the Mid-Atlantic Changes - January 1997

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

#### Benefit changes

- If your primary care physician is part of a group practice or physicians' association, you must receive speciality care from that group. If your group does not have a specialist you need, the Plan will arrange for your speciality referral.
- The Plan has instituted a self-referral process for most gynecological care. See "limited benefits" on page 12.

- Single lung, double lung, heart/lung, and pancreas/kidney transplants are now covered. These transplants were previously excluded.
- Under the maternity care benefit, for both options, an enrollee will have to pay a copay for the first maternity care visit. Subsequent maternity care copays for that pregnancy will be waived. Previously, the maternity care copay was waived for all maternity care visits.
- The Plan has added a restorative benefit for injuries occurring to sound natural teeth (see page 13). Previously, the Plan did not have an accidental injury benefit.
- Copays for most dental care services have been increased. See page 18 for specific copay levels.
- The Plan has added a hospice benefit for up to 180 days per member (see page 13). Previously, the Plan did not have a hospice benefit.
- The Plan now covers oral and suppository fertility drugs at 50% of charges (see "treatment of infertility, page 12). Previously, fertility drugs were not covered.
- The exclusion for the cost of processing whole blood, blood components, and blood derivatives has been removed.
- Under the Prescription drug benefit, for both options, coverage is limited to up to a 30-day supply; diabetic test strips and lancets are covered; and topical fluoride preparations are excluded. Previously, drugs were provided for up to a 30-day supply or 100 unit dosage, whichever is less; diabetic test strips and lancets were excluded; and the coverage of topical fluoride preparations was not addressed.
- Under the Prescription drug benefit, for both options, generic drugs purchased at a Plan pharmacy are covered at a \$4 copay, and name brand drugs an \$8 copay per prescription or refill. Previously, the copays were \$2 and \$7 for generic and name brand drugs, respectively, per prescripition or refill.
- The Home Delivery Pharmacy Service now charges \$8 per prescription or refill (for both generic and name brand drugs) for up to a 90-day supply per prescription or refill. Previously, the Home Delivery Pharmacy Service charged a \$2 copay for generic drugs and a \$7 copay for name brand drugs, per prescription or refill. The provision providing for up to a 90-day supply was previously not addressed.
- Members purchasing a prescription drug from a non-participating pharmacy outside the Plan's service area due to a medical emergency may claim reimbursement for up to a 10 day supply per prescription. The member must pay the applicable copay or prescription drug deductible. This was previously not addressed.

#### Clarifications

- Your costs for orthopedic devices are not included in the Plan's out-of-pocket maximum.
- Under the "referrals for specialty care" section, referral instructions apply to both specialists and consultants. Previously, this was not specifically addressed.
- Orthotics and immunizations not medically required are excluded. Previously, these exclusions were not specifically addressed.
- The section "who provides care to Plan members" has been clarified to show that members must select one primary care dentist for the entire family.
- 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 benefit "Nonexperimental implants" is now termed "The insertion of internal prosthetic devices".

Other changes

- The Plan has changed its name from HealthPlus, Inc. to NYLCare Health Plans of the Mid-Atlantic, Inc.
- The Plan has expanded its service and enrollment area to include the Virginia Counties of Amelia, Nottoway, Powhatan, Surry, and Sussex.
- 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.
- 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) or an equivalent agency to be payable under workers' compensation or similar Federal or State law. The Plan is entitled to be reimbursed by OWCP or the equivalent agency for services it provided that were later found to be payable by OWCP or the agency.
- Disputed claims If your claim for payment or services is denied by the Plan, and you decide to ask OPM to review that denial, you must first ask the Plan 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 NYLCare Health Plans of the Mid-Atlantic, Inc.-  
1997

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

Benefits	High Option pays/provides	Page
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Inpatient care

Hospital

Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing

care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay nothing.....13

Extended Care

All necessary services, up to 60 days per member per year; you pay nothing.....13

Mental Conditions

Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per calendar year. You pay a \$50 copay per day.....15-16

Substance Abuse

Covered under Mental conditions.....16

Outpatient care

Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. You pay a \$5 copay per office visit or house call by a doctor (office visit copays are waived for care after the first maternity care visit).....11-12

Home Health Care

All necessary visits by nurses and health aides. You pay nothing.....12

Mental Conditions

Up to 50 outpatient visits per calendar year. You pay a \$25 copay per visit.....15

Substance Abuse

Covered under Mental conditions.....15

Emergency care

Reasonable charges for services and supplies required because of a medical emergency. You pay a \$40 copay to the hospital for each emergency room visit and any charges for services that are not covered benefits of this Plan.....14-15

Prescription drugs

Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy or from the Home Delivery Pharmacy Service. You pay a \$4 copay for generic drugs or a \$8 copay for name brand drugs per prescription unit or refill at a Plan pharmacy, \$8 per prescription through the Home Delivery Pharmacy Service.....16

Dental care

Full dental care; you pay copays for most services.....	18
Vision care	
Comprehensive vision benefit. You pay a \$25 copay per eye exam and various copays for lenses and frames.....	17
Out-of-pocket limit	
Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of \$650 per Self Only or \$1,500 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include costs of dental services, prescription drugs, vision care, durable medical equipment, orthopedic devices, inpatient care of mental conditions/substance abuse, and vision care.....	8
Standard Option pays/provides	Page
Inpatient care	
Hospital	
Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. You pay a \$200 copay per medical admission; a \$400 copay per surgical or maternity admission; a \$50 copay per outpatient surgical visit.....	13
Extended care	
All necessary services, for up to 60 days per member per year; you pay nothing.....	13
Mental Conditions	
Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per calendar year. You pay a \$50 copay per day.....	15-16
Substance Abuse	
Covered under Mental conditions.....	16
Outpatient care	
Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. You pay a \$10 copay per office visit or house call by a doctor (office visit copays are waived for care after the first maternity care visit).....	16
Home Health Care	

All necessary visits by nurses and health aides. You pay nothing....11-12  
Mental Conditions

Up to 50 outpatient visits per calendar year. You pay a \$25 copay per  
visit.....15

Substance Abuse

Covered under Mental conditions.....15

Emergency care

Reasonable charges for services and supplies required because of a medical  
emergency. You pay a \$25 copay to the hospital for each emergency room  
visit and any charges for services that are not covered benefits of this  
Plan .....14-15

Prescription drugs

Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. You pay  
a \$4 copay for generic drugs or a \$8 copay for name brand drugs per  
prescription unit or refill after each member meets the annual \$75  
deductible; you pay a \$8 copay for generic drugs or name brand drugs per  
prescription unit or refill, but no deductible, for Home Delivery Pharmacy  
Service.....16

Dental care

Full dental care; you pay copays for most services.....18

Vision care

No current benefit

Out-of-pocket-limit

Copayments are required for a few benefits; however, after your  
out-of-pocket expenses reach a maximum of \$1,000 per Self Only or \$2,500  
per Self and Family enrollment per calendar year, covered benefits will be  
provided at 100%. This copay maximum does not include costs of dental  
services, prescription drugs, durable medical equipment, orthopedic  
devices, and inpatient care of mental conditions/substance  
abuse.....8