Blue Cross® and Blue Shield® Service Benefit Plan

www.fepblue.org

2016

A fee-for-service plan (standard and basic option) with a preferred provider organization

IMPORTANT:

- Rates: Back Cover
- Changes for 2016: Page 15
- Summary of benefits: Page 156

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 9 for details.

Sponsored and administered by: The Blue Cross and Blue Shield Association and participating Blue Cross and Blue Shield Plans

Who may enroll in this Plan: All Federal employees, Tribal employees, and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program

Enrollment codes for this Plan:

104 Standard Option - Self Only
106 Standard Option - Self Plus One
105 Standard Option - Self and Family
111 Basic Option - Self Only
113 Basic Option - Self Plus One
112 Basic Option - Self and Family

urac ACCREDITED Case Management Expires 08/01/2016

NCQA CASE MANAGEMENT ACCREDITATION

NCQA HEALTH PLAN ACCREDITATION

The Case Management programs for this Plan are accredited through URAC or NCQA, or through Health Plan accreditation from NCQA.

FEHB Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Healthcare and Insurance
www.opm.gov/healthcare-insurance

RI 71-005

Important Notice from the Blue Cross and Blue Shield Service Benefit Plan About Our Prescription Drug Coverage and Medicare

OPM has determined that the Blue Cross and Blue Shield Service Benefit Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY: 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048).

Table of Contents

Introduction

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan** under our contract (CS 1039) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan in their individual localities. For customer service assistance, visit our website, www.fepblue.org, or contact your Local Plan at the telephone number appearing on the back of your ID card.

The Blue Cross and Blue Shield Association is the Carrier of the Plan. The address for the Blue Cross and Blue Shield Service Benefit Plan administrative office is:

Blue Cross and Blue Shield Service Benefit Plan
1310 G Street NW, Suite 900
Washington, DC 20005

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health care benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. If you enroll in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2016, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2016, and changes are summarized on pages 15-17. Rates are shown on the back cover of this brochure.

Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this Plan meets the minimum value standard for the benefits the Plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means the Blue Cross and Blue Shield Service Benefit Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.

- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call the FEP Fraud Hotline at 1-800-FEP-8440 (1-800-337-8440) and explain the situation.
  - If we do not resolve the issue:

CALL — THE HEALTH CARE FRAUD HOTLINE
1-877-499-7295
OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/
The online form is the desired method of reporting fraud in order to ensure accuracy, and a quick response time.
You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. **Keep and bring a list of all the medicines you take.**
   - Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosages that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
   - Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
   - Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
   - Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
   - Read the label and patient package insert when you get your medicine, including all warnings and instructions.
   - Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
   - Contact your doctor or pharmacist if you have any questions.
3. **Get the results of any test or procedure.**
   - Ask when and how you will get the results of tests or procedures.
   - Do not assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
   - Call your doctor and ask for your results.
   - Ask what the results mean for your care.
4. **Talk to your doctor about which hospital is best for your health needs.**
   - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
   - Be sure you understand the instructions you get about follow-up care when you leave the hospital.
5. **Make sure you understand what will happen if you need surgery.**
   - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
   - Ask your doctor, "Who will manage my care when I am in the hospital?"
   - Ask your surgeon:
     - "Exactly what will you be doing?"
     - "About how long will it take?"
     - "What will happen after surgery?"
     - "How can I expect to feel during recovery?"
   - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you use Service Benefit Plan Preferred or Member hospitals. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/healthcare-insurance/healthcare for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies that participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment
- How you can cover your family members
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
- What happens when your enrollment ends
- When the next Open Season for enrollment begins

We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family or Self Plus One enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

If you have a qualifying life event (QLE) – such as marriage, divorce, or the birth of a child – outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by valid common-law marriage if you reside in a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and one eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural children, adopted children, and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2016 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2015 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service), and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC).

- **Upon divorce**

If you are divorced from a Federal employee or annuitant you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health benefits coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn age 26, regardless of marital status, etc.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB~~P~~ coverage.

- **Finding replacement coverage**

This Plan no longer offers its own non-FEHB plan for conversion purposes. If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please refer to the next section of this brochure. Although we no longer offer conversion coverage, we will help you find replacement coverage inside or outside the Marketplace. For assistance, please contact your Local Plan at the telephone number appearing on the back of your ID card, or visit www.bcbs.com to access the website of your Local Plan.

Note: We do not determine who is eligible to purchase health benefits coverage inside the Affordable Care Act's Health Insurance Marketplace. These rules are established by the Federal Government agencies that have responsibility for implementing the Affordable Care Act and by the Marketplace.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this Plan works

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

General features of our Standard and Basic Options

We have a Preferred Provider Organization (PPO)

Our fee-for-service plan offers services through a PPO. This means that certain hospitals and other health care providers are "Preferred providers." When you use our PPO (Preferred) providers, you will receive covered services at a reduced cost. Your Local Plan (or, for retail pharmacies, CVS Caremark) is solely responsible for the selection of PPO providers in your area. Contact your Local Plan for the names of PPO (Preferred) providers and to verify their continued participation. You can also visit www.fepblue.org/provider/ to use our National Doctor & Hospital Finder[SM]. You can reach our website through the FEHB website, www.opm.gov/healthcare-insurance.

Under Standard Option, PPO (Preferred) benefits apply only when you use a PPO (Preferred) provider. PPO networks may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas. If no PPO (Preferred) provider is available, or you do not use a PPO (Preferred) provider, non-PPO (Non-preferred) benefits apply.

Under Basic Option, you must use Preferred providers in order to receive benefits. See page 21 for the exceptions to this requirement.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

How we pay professional and facility providers

We pay benefits when we receive a claim for covered services. Each Local Plan contracts with hospitals and other health care facilities, physicians, and other health care professionals in its service area, and is responsible for processing and paying claims for services you receive within that area. Many, but not all, of these contracted providers are in our PPO (Preferred) network.

- **PPO providers.** PPO (Preferred) providers have agreed to accept a specific negotiated amount as payment in full for covered services provided to you. **We refer to PPO facility and professional providers as "Preferred."** They will generally bill the Local Plan directly, who will then pay them directly. You do not file a claim. Your out-of-pocket costs are generally less when you receive covered services from Preferred providers, and are limited to your coinsurance or copayments (and, under **Standard Option** only, the applicable deductible).
- **Participating providers.** Some Local Plans also contract with other providers that are not in our Preferred network. **If they are professionals, we refer to them as "Participating" providers. If they are facilities, we refer to them as "Member" facilities.** They have agreed to accept a different negotiated amount than our Preferred providers as payment in full. They will also generally file your claims for you. They have agreed not to bill you for more than your applicable deductible, and coinsurance or copayments, for covered services. We pay them directly, but at our Non-preferred benefit levels. Your out-of-pocket costs will be greater than if you use Preferred providers.

  Note: Not all areas have Participating providers and/or Member facilities. To verify the status of a provider, please contact the Local Plan where the services will be performed.

- **Non-participating providers.** Providers who are not Preferred or Participating providers do not have contracts with us, and may or may not accept our allowance. **We refer to them as "Non-participating providers" generally, although if they are facilities we refer to them as "Non-member facilities."** When you use Non-participating providers, you may have to file your claims with us. We will then pay our benefits to you, and you must pay the provider.

  You must pay any difference between the amount Non-participating providers charge and our allowance (except in certain circumstances – see pages 148-150). In addition, you must pay any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for noncovered services. **Important: Under Standard Option, your out-of-pocket costs may be substantially higher when you use Non-participating providers than when you use Preferred or Participating providers.** Under Basic Option, you must use Preferred providers to receive benefits. See page 21 for the exceptions to this requirement.

  Note: In Local Plan areas, Preferred providers and Participating providers who contract with us will accept 100% of the Plan allowance as payment in full for covered services. As a result, you are only responsible for applicable coinsurance or copayments (and, under **Standard Option** only, the applicable deductible), for covered services, and any charges for noncovered services.

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Care management, including medical practice guidelines;
- Disease management programs; and
- How we determine if procedures are experimental or investigational.

If you want more information about us, call or write to us. Our telephone number is shown on the back of your Service Benefit Plan ID card. You may also visit our website at www.fepblue.org.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. ***Note:*** As part of our administration of this contract, we may disclose your medical and claims information (including your prescription drug utilization) to any treating physicians or dispensing pharmacies. You may view our Notice of Privacy Practice for more information about how we may use and disclose member information by visiting our website at www.fepblue.org.

Section 2. Changes for 2016

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 (*Benefits*). Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- Self Plus One enrollment type has been added effective January 1, 2016.

Changes to our Standard Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. (See page 160.)
- For Self Plus One and Self and Family contracts, your catastrophic out-of-pocket maximum is now $10,000 per year when you use Preferred providers, and $14,000 per year when you use a combination of Preferred and Non-preferred providers. Previously, the out-of-pocket maximum for Self and Family contracts was $6,000 for Preferred provider services and $8,000 for a combination of Preferred and Non-preferred provider services.
- For Self Plus One and Self and Family contracts, when one covered family member reaches the Self Only catastrophic out-of-pocket maximums ($5,000 for Preferred, or $7,000 for a combination of Preferred and Non-preferred providers) during the calendar year, that member's claims will no longer be subject to associated cost-sharing amounts for the rest of the year. Previously, all covered family members were required to satisfy the maximums, in combination, before any member's claims were no longer subject to associated member cost-sharing amounts for the rest of the year. (See page 32.)
- Your copayment for manipulative treatment performed by a Preferred provider is now $25 per visit. Previously, your copayment was $20 per visit. (See page 63.)
- Your copayment for professional mental health care and substance abuse services performed by a Preferred provider is now $25 per visit. Previously, your copayment was $20 per visit. (See page 99.)
- Your copayment for office visits, physical therapy, speech therapy, occupational therapy, cognitive therapy, vision services, and foot care services performed by Preferred primary care providers or other health care professionals is now $25 per visit. Previously, your copayment for these services was $20 per visit. (See Section 5(a).)
- Your copayment for office visits, physical therapy, speech therapy, occupational therapy, cognitive therapy, vision services, or foot care services performed by Preferred specialists is now $35 per visit. Previously, your copayment for these services was $30 per visit. (See Section 5(a).)
- Your copayment for outpatient observation services billed by a Preferred facility is now $350 for the duration of services. When billed by a Member or Non-member facility, your cost-share includes a $450 copayment plus 35% coinsurance. For Non-member facilities, you are also responsible for the difference between the billed charge and the Plan allowance. Previously, you were responsible for the calendar year deductible and 15% coinsurance when billed by a Preferred facility, or 35% coinsurance when billed by a Member or Non-member facility. (See page 84.)
- Your cost-share for an inpatient admission to a Preferred hospital or other covered facility is now a $350 copayment for unlimited days. When admitted to a Member or Non-member hospital or other covered facility, your cost-share is now a $450 copayment for unlimited days, plus 35% of the Plan allowance. For Non-member providers, you are also responsible for any remaining balance after our payment. Previously, you were responsible for a $250 per admission copayment for Preferred providers, and a $350 per admission copayment plus 35% of the Plan allowance for Member and Non-member providers. (See pages 80-81.) There is no change to the cost-share for admission to a Non-member mental health and substance abuse facility.
- Your cost-share for Continuous Home Hospice care performed by Preferred providers is now a $350 per episode copayment. When performed by Member or Non-member providers, your cost-share is now a $450 per episode copayment. For Non-member providers, you are also responsible for 35% of the Plan allowance, plus any remaining balance after our payment. Previously, you were responsible for a $250 per episode copayment for Preferred providers, and a $350 per episode copayment for Member and Non-member providers. (See page 91.)
- Your dental benefits are now limited to coverage for clinical oral evaluations, diagnostic imaging, palliative treatment, and preventive procedures. (See pages 116-117.)

Changes to our Basic Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. (See page 160.)
- For Self Plus One and Self and Family contracts, your catastrophic out-of-pocket maximum is now $11,000 per year when you use Preferred providers. Previously, the out-of-pocket maximum for Self and Family contracts was $7,000 for Preferred provider services.
- For Self Plus One and Self and Family contracts, when one covered family member reaches the Self Only catastrophic protection out-of-pocket maximum ($5,500) during the calendar year, that member's claims will no longer be subject to associated member cost-sharing amounts for the rest of the year. Previously, all covered family members were required to satisfy the maximum, in combination, before any member's claims were no longer subject to associated member cost-sharing amounts for the rest of the year.
- Your copayment for home nursing visits performed by Preferred providers is now $30 per visit. Previously, your copayment was $25 per visit. (See page 62.)
- Your copayment for manipulative treatment services performed by Preferred providers is now $30 per visit. Previously, your copayment was $25 per visit. (See page 63.)
- Your copayment for mental health care and substance abuse services performed by Preferred providers is now $30 per visit. Previously, your copayment was $25 per visit. (See page 99.)
- Your copayment for dental care services performed by Preferred providers is now $30 per visit or evaluation. Previously, your copayment was $25 per visit or evaluation. (See pages 115 and 118.)
- Your copayment for office visits, reproductive services, allergy care, treatment therapies, physical therapy, speech therapy, occupational therapy, cognitive therapy, hearing services, vision services, foot care services, alternative treatments or diabetic education performed by Preferred primary care providers or other health care professionals is now $30 per visit. Previously, your copayment for these services was $25 per visit. (See Section 5(a).)
- Your copayment for office visits, reproductive services, allergy care, treatment therapies, physical therapy, speech therapy, occupational therapy, cognitive therapy, hearing services, vision services, foot care services, alternative treatments or diabetic education performed by Preferred specialists is now $40 per visit. Previously, your copayment for these services was $35 per visit. (See Section 5(a).)
- Your copayment for outpatient observation services billed by a Preferred hospital or freestanding ambulatory facility is now $175 per day up to a maximum of $875. Previously, your copayment for these services was $100 per day per facility. (See page 84.)
- Your prescription drug benefits now include a managed formulary for covered prescription drugs and supplies. Visit our website at www.fepblue.org, to view the formulary. See Section 5(f) for more information.
- We now provide Mail Service Prescription Drug Program benefits to Basic Option members who have primary Medicare Part B coverage. See Section 5(f) for details.
- Your copayment for Tier 2 preferred brand-name drugs dispensed by a Preferred Retail Pharmacy is now $50 for a 30-day supply. Previously, you paid $45 for Tier 2 preferred brand-name drugs. If you have primary coverage under Medicare Part B, your copayment for Tier 2 drugs is still $45 for a 30-day supply. (See page 110.)
- Your cost-share for Tier 3 non-preferred brand-name drugs dispensed by a Preferred Retail Pharmacy is now 60% coinsurance with a $65 minimum copayment for a 30-day supply. Previously, you paid 50% coinsurance with a $55 minimum copayment for Tier 3 non-preferred brand-name drugs. If you have primary coverage under Medicare Part B, your cost-share for Tier 3 drugs is still 50% coinsurance with a $55 minimum copayment for a 30-day supply. (See page 110.)
- Your copayment for Tier 4 preferred specialty drugs dispensed by a Preferred Retail Pharmacy is now $65 for a 30-day supply. Previously, you paid $60 for Tier 4 preferred specialty drugs. If you have primary coverage under Medicare Part B, your copayment for Tier 4 drugs is still $60 for a 30-day supply. (See page 110.)
- Your copayment for Tier 5 non-preferred specialty drugs dispensed by a Preferred Retail Pharmacy is now $90 for a 30-day supply. Previously, you paid $80 for Tier 5 non-preferred specialty drugs. If you have primary coverage under Medicare Part B, your copayment for Tier 5 drugs is still $80 for a 30-day supply. (See page 110.)
- Your copayment for Tier 4 preferred specialty drugs dispensed through the Specialty Drug Pharmacy Program is now $55 for a 30-day supply, or $165 for a 31- to 90-day supply. Previously, you paid $50 for a 30-day supply, or $140 for a 90-day supply of Tier 4 preferred specialty drugs. If you have primary coverage under Medicare Part B, your copayment for Tier 4 drugs is still $50 for a 30-day supply, or $140 for a 90-day supply. (See page 112.)
- Your copayment for Tier 5 non-preferred specialty drugs dispensed through the Specialty Drug Pharmacy Program is now $80 for a 30-day supply, or $240 for a 31- to 90-day supply. Previously, you paid $70 for a 30-day supply, or $195 for a 90-day supply of Tier 5 non-preferred specialty drugs. If you have primary coverage under Medicare Part B, your copayment for Tier 5 drugs is still $70 for a 30-day supply, or $195 for a 90-day supply. (See page 112.)

Changes to both our Standard and Basic Options

- After completing your Blue Health Assessment (BHA), you are now entitled to receive up to $120 in rewards on your health account for achieving up to three Online Health Coach goals. Previously, you were eligible to receive up to $35 in rewards. New eligible goals are **heart disease, heart failure, chronic obstructive pulmonary disease (COPD), and asthma**. They join the existing reward-eligible goals, **exercise, nutrition, weight management, stress, and emotional health**. (See Section 5(h).)
- We now limit Preventive care benefits for an ultrasound for abdominal aortic aneurysm to adults ages 65 to 75, also limited to one test per lifetime. Previously, Preventive care benefits were available for this test for all adult members once per calendar year. (See page 43.)
- We now provide Preventive care benefits for osteoporosis screening, once per calendar year, for women age 65 and over, and for women ages 50 to 65 that have increased risk for osteoporosis. Previously, Preventive care benefits were available for this test for female members age 60 and older once per calendar year. (See page 43.)
- We now provide Preventive care benefits for hepatitis B screening for adults, and for adolescents, age 13 and over. Previously, Preventive care benefits were not available for this type of screening. (See pages 42 and 47).
- We now provide Preventive care benefits for the application of fluoride varnish, up to two per calendar year, for children through age 5, when administered by a primary care provider. Previously, Preventive care benefits were not available. (See page 47.)
- We now provide Preventive care benefits for low-dose aspirin as a preventive medication for pregnant women who are at risk for preeclampsia. Previously, benefits were not available for this service. (See page 109.)
- We now provide Preventive care benefits for the following BRCA-related testing for members age 18 and over: BRCA1 and BRCA2 testing for individuals from a family with a known BRCA1/BRCA2 mutation; BRCA1 and BRCA2 testing for members who have a personal history of breast, ovarian, fallopian tube, peritoneal, pancreatic and/or prostate cancer, who have not received BRCA testing, when genetic counseling and evaluation supports BRCA testing; and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes. Prior approval is required for testing. See pages 41 and 44-45 for additional details.
- We now provide allergy care and prescription drug benefits for specific FDA-approved drugs for sublingual allergy desensitization. Previously, benefits were not available for these services. (See pages 53 and 114).
- You are no longer required to obtain prior approval for outpatient intensity modulated radiation therapy (IMRT) services related to the treatment of anal cancer. Previously, prior approval was required for outpatient IMRT for this type of cancer. (See page 23.)
- You now pay a copayment of $100 per day per facility under Standard Option and $25 per day per facility under Basic Option when you use a Blue Distinction Center for Bariatric Surgery for outpatient laparoscopic gastric stapling surgical procedures. Regular benefit levels apply to charges for the professional services, including surgery and anesthesia. Previously, these benefits were only available for laparoscopic gastric banding procedures performed in one of these facilities. (See page 87.)
- We now use the Local Plan allowance as our Plan allowance for outpatient dialysis services performed by Non-member facilities. Previously, our Plan allowance was equal to the billed charge for outpatient dialysis services performed by Non-member facilities. (See page 149.)
- We now provide benefits for inpatient admissions to residential treatment centers for treatment of medical, mental health, and/or substance abuse conditions when performed and billed by a licensed and accredited residential treatment center based on specific criteria. Previously, benefits for inpatient care provided by a residential treatment center were only available to Standard Option members with primary Medicare Part A coverage. (See pages 88 and 100.)
- We now provide Prescription drug benefits for the treatment of gender identity/gender dysphoria. Benefits are available only when these drugs are obtained through the Retail Pharmacy Program, Specialty Pharmacy Program or Mail Service Prescription Drug Program. Previously, benefits were excluded for drugs used as part of the treatment of gender identity/gender dysphoria. (See page 107.)
- Members with high blood pressure who complete the BHA may receive a free blood pressure monitor every two years through our Hypertension Management Program. (See Section 5(h) Special features for eligibility criteria and more information about the program.)
- We now provide a Pregnancy Care Incentive Program for pregnant members age 18 and over who receive prenatal care in the first trimester of their pregnancy and submit a copy of the provider's medical record documenting the prenatal care visit. (See Section 5(h) for details about the Pregnancy Care Incentive Program.)

Section 3. How you receive benefits

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You will need it whenever you receive services from a covered provider, or fill a prescription through a Preferred retail pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call the Local Plan serving the area where you reside and ask them to assist you, or write to us directly at: FEP® Enrollment Services, 840 First Street NE, Washington, DC 20065. You may also request replacement cards through our website, www.fepblue.org.

Where you get covered care

Under Standard Option, you can get care from any "covered professional provider" or "covered facility provider." How much we pay – and you pay – depends on the type of covered provider you use. If you use our Preferred, Participating, or Member providers, you will pay less.

Under Basic Option, you **must** use those "covered professional providers" or "covered facility providers" that are **Preferred providers** for Basic Option in order to receive benefits. Please refer to page 21 for the exceptions to this requirement. Refer to page 13 for more information about Preferred providers.

The term "primary care provider" includes family practitioners, general practitioners, medical internists, pediatricians, obstetricians/gynecologists, and physician assistants.

• Covered professional providers

We provide benefits for the services of covered professional providers, as required by Section 2706(a) of the Public Health Service Act (PHSA). Covered professional providers are health care providers who perform covered services when acting within the scope of their license or certification under applicable state law and who furnish, bill, or are paid for their health care services in the normal course of business. Covered services must be provided in the state in which the provider is licensed or certified. Your Local Plan is responsible for determining the provider's licensing status and scope of practice. As reflected in Section 5, the Plan does limit coverage for some services, in accordance with accepted standards of clinical practice regardless of the geographic area.

- **Under Standard Option,** we cover any licensed professional provider for covered services performed within the scope of that license.
- **Under Basic Option,** we cover any licensed professional provider who is **Preferred** for covered services performed within the scope of that license.

Covered professional providers include:

- **Physicians –** Doctors of medicine (M.D.); Doctors of osteopathy (D.O.); Doctors of dental surgery (D.D.S.); Doctors of medical dentistry (D.M.D.); Doctors of podiatric medicine (D.P.M.); Doctors of optometry (O.D.); and Doctors of Chiropractic/chiropractors (D.C.); and
- **Other Covered Health Care Professionals –** Professionals such as the health care providers listed below and on the next page, when they provide covered services *and* meet the state's applicable licensing or certification requirements. **If the state has no applicable licensing or certification requirement, the provider must meet the requirements of the Local Plan.**
  - Audiologist
  - Clinical Psychologist
  - Clinical Social Worker
  - Diabetic Educator
  - Dietician
  - Independent Laboratory
  - Lactation Consultant
  - Mental Health or Substance Abuse professional

- Certified Midwife
- Nurse Practitioner/Clinical Specialist
- Nursing School Administered Clinic
- Nutritionist
- Physical, Speech, and Occupational Therapist
- Physician Assistant

• Covered facility providers

Covered facilities include those listed below, when they meet the state's applicable licensing or certification requirements.

Hospital – An institution, or a distinct portion of an institution, that:

1. Primarily provides diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of injured and sick persons provided or supervised by a staff of licensed doctors of medicine (M.D.) or licensed doctors of osteopathy (D.O.), for compensation from its patients, on an inpatient or outpatient basis;
2. Continuously provides 24-hour-a-day professional registered nursing (R.N.) services; and
3. Is not, other than incidentally, an extended care facility; a nursing home; a place for rest; an institution for exceptional children, the aged, drug addicts, or alcoholics; or a custodial or domiciliary institution having as its primary purpose the furnishing of food, shelter, training, or non-medical personal services.

Note: We consider college infirmaries to be Non-member hospitals. In addition, we may, at our discretion, recognize any institution located outside the 50 states and the District of Columbia as a Non-member hospital.

Freestanding Ambulatory Facility – A freestanding facility, such as an ambulatory surgical center, freestanding surgi-center, freestanding dialysis center, or freestanding ambulatory medical facility, that:

1. Provides services in an outpatient setting;
2. Contains permanent amenities and equipment primarily for the purpose of performing medical, surgical, and/or renal dialysis procedures;
3. Provides treatment performed or supervised by doctors and/or nurses, and may include other professional services performed at the facility; and
4. Is not, other than incidentally, an office or clinic for the private practice of a doctor or other professional.

Note: We may, at our discretion, recognize any other similar facilities, such as birthing centers, as freestanding ambulatory facilities.

Residential Treatment Center – Residential treatment centers (RTCs) are accredited by a nationally recognized organization and licensed by the state, district, or territory to provide residential treatment for medical conditions, mental health conditions, and/or substance abuse. Accredited health care facilities (excluding hospitals, skilled nursing facilities, group homes, halfway houses, and similar types of facilities) provide 24-hour residential evaluation, treatment and comprehensive specialized services relating to the individual's medical, physical, mental health, and/or substance abuse therapy needs. RTCs offer programs for persons who need short-term transitional services designed to achieve predicted outcomes focused on fostering improvement or stability in functional, physical and/or mental health, recognizing the individuality, strengths, and needs of the persons served. Benefits are available for services performed and billed by RTCs, as described on pages 88 and 100. If you have questions about treatment at an RTC, please contact us at the customer service number listed on the back of your ID card.

Blue Distinction Centers®

Certain facilities have been selected to be Blue Distinction Centers for Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Spine Surgery, and Complex and Rare Cancers. These facilities meet objective quality criteria established with input from expert physician panels, surgeons, and other medical professionals. Blue Distinction Centers offer comprehensive care delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise.

We cover facility costs for specialty care at designated Blue Distinction Centers at Preferred benefit levels, which means that your out-of-pocket expenses for specialty facility services are limited. In addition, we provide enhanced benefits for covered inpatient facility services related to specific bariatric, knee, hip, and spine surgical procedures, when the surgery is performed at a Blue Distinction Center. We also provide enhanced benefits for covered facility services related to outpatient laparoscopic gastric banding and gastric stapling surgical procedures, when the surgery is performed at a Blue Distinction Center for Bariatric Surgery. See page 87 for more information.

Facility care that is not part of the Blue Distinction Program is reimbursed according to the network status of the facility. In addition, some Blue Distinction Centers may use professional providers who do not participate in our provider network. Non-participating providers have no agreements with us to limit what they can bill you. This is why it's important to always request Preferred providers for your care. For more information, see pages 27-32 in Section 4, *Your costs for covered services*, or call your Local Plan at the number listed on the back of your ID card. For listings of Preferred providers in your area, visit www.fepblue.org/provider to use our National Doctor & Hospital Finder.

If you are considering covered bariatric surgery, cardiac procedures, knee or hip replacement, spine surgery, or inpatient treatment for a complex or rare cancer, you may want to consider receiving those services at a Blue Distinction Center. To locate a Blue Distinction Center, visit www.fepblue.org/provider to use our National Doctor & Hospital Finder, or call us at the customer service number listed on the back of your ID card.

Blue Distinction Centers for Transplants®

In addition to the Blue Distinction Centers listed above, you have access to Blue Distinction Centers for Transplants. Blue Distinction Centers for Transplants are selected based on their ability to meet defined clinical quality criteria that are unique for each type of transplant. We provide enhanced benefits for covered transplant services performed at these designated centers as described on page 77.

Regular benefits (subject to the regular cost-sharing levels for facility and professional services) are paid for pre- and post-transplant services performed in Blue Distinction Centers for Transplants before and after the transplant period. (Regular benefit levels and cost-sharing amounts also apply to services unrelated to a covered transplant.)

Cancer Research Facility – A facility that is:

1. A National Cooperative Cancer Study Group institution that is funded by the National Cancer Institute (NCI) and has been approved by a Cooperative Group as a blood or marrow stem cell transplant center;
2. An NCI-designated Cancer Center; or
3. An institution that has a peer-reviewed grant funded by the National Cancer Institute (NCI) or National Institutes of Health (NIH) to study allogeneic or autologous blood or marrow stem cell transplants.

FACT-Accredited Facility

A facility with a transplant program accredited by the Foundation for the Accreditation of Cellular Therapy (FACT). FACT-accredited cellular therapy programs meet rigorous standards. Information regarding FACT transplant programs can be obtained by contacting the transplant coordinator at the customer service number listed on the back of your ID card or by visiting www.factwebsite.org.

Note: Certain stem cell transplants **must** be performed at a FACT-accredited facility (see page 75).

Other facilities specifically listed in the benefits descriptions in Section 5(c).

What you must do to get covered care

Under Standard Option, you can go to any covered provider you want, but in some circumstances, we must approve your care in advance.

Under Basic Option, you **must** use **Preferred** providers in order to receive benefits, except under the situations listed below. In addition, we must approve certain types of care in advance. Please refer to Section 4, *Your costs for covered services*, for related benefits information.

1. Medical emergency or accidental injury care in a hospital emergency room and related ambulance transport as described in Section 5(d), *Emergency services/accidents*;
2. Professional care provided at Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons;
3. Laboratory and pathology services, X-rays, and diagnostic tests billed by Non-preferred laboratories, radiologists, and outpatient facilities;
4. Services of assistant surgeons;
5. Care received outside the United States, Puerto Rico, and the U.S. Virgin Islands; or
6. Special provider access situations, other than those described above. We encourage you to contact your Local Plan for more information in these types of situations before you receive services from a Non-preferred provider.

Unless otherwise noted in Section 5, when services are covered under Basic Option exceptions for Non-preferred provider care, you are responsible for the applicable coinsurance or copayment, and may also be responsible for any difference between our allowance and the billed amount.

• Transitional care

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan, or
- lose access to your Preferred specialist because we terminate our contract with your specialist for reasons other than for cause,

you may be able to continue seeing your specialist and receiving any Preferred benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and your Preferred benefits will continue until the end of your postpartum care, even if it is beyond the 90 days.

• If you are hospitalized when your enrollment begins

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call us immediately. If you have not yet received your Service Benefit Plan ID card, you can contact your Local Plan at the telephone number listed in your local telephone directory. If you already have your new Service Benefit Plan ID card, call us at the number on the back of the card. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

However, if you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for *Other services* (called prior approval), are detailed in this Section. A **pre-service claim** is any claim, in whole or in part, that requires approval from us before you receive medical care or services. In other words, a pre-service claim for benefits (1) requires precertification or prior approval and (2) will result in a reduction or denial of benefits if you do not obtain precertification or prior approval.

- **Inpatient hospital admission or inpatient residential treatment center admission**

Precertification is the process by which – prior to your inpatient hospital or inpatient residential treatment center admission – we evaluate the medical necessity of your proposed stay, the procedure(s)/service(s) to be performed, the number of days required to treat your condition, and any applicable benefit criteria. Unless we are misled by the information given to us, we will not change our decision on medical necessity.

In most cases, your physician or facility will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician, hospital or inpatient residential treatment center whether they have contacted us. For information about precertification of an emergency inpatient hospital admission, please see page 25.

Warning:

We will reduce our benefits for the inpatient hospital stay by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will not provide benefits for inpatient hospital room and board or inpatient physician care; we will only pay for covered medical services and supplies that are otherwise payable on an outpatient basis.

Note: Benefits are not available for inpatient care provided or billed by a residential treatment center if precertification was not obtained prior to admission. We will pay only for covered medical services and supplies that are otherwise payable on an outpatient basis.

Exceptions:

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payor for the hospital stay. (See page 77 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)
- Medicare Part A is the primary payor for the hospital stay. (See page 77 for special instructions regarding admissions to Blue Distinction Centers for Transplants.)

  Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then you **do** need precertification.

  Note: Morbid obesity surgery performed during an inpatient stay (even when Medicare Part A is your primary payor) must meet the surgical requirements described on pages 65-68 in order for benefits to be provided for the admission and surgical procedure.

Note: Precertification is required for residential treatment center admission.

- **Other services**

You must obtain prior approval for these services under both Standard and Basic Option. Contact us using the customer service number listed on the back of your ID card before receiving these types of services, and we will request the medical evidence needed to make a coverage determination:

- **BRCA testing and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes –** Prior approval is required for BRCA testing and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes whether performed for preventive or diagnostic reasons. Contact us at the customer service number listed on the back of your ID card to request prior approval before receiving the test. We will request the medical evidence we need to make our coverage determination.

  Note: **You must receive genetic counseling and evaluation services before preventive BRCA testing is performed.** See page 44.

- **Outpatient surgical services –** When performed on an outpatient basis, the surgical services listed on the next page require prior approval for care performed by Preferred, Participating/Member, and Non-participating/Non-member professional and facility providers.

- Outpatient surgery for morbid obesity. ***Note:*** Benefits for the surgical treatment of morbid obesity – performed on an inpatient or outpatient basis – are subject to the pre-surgical requirements listed on pages 65-68;
- Outpatient surgical correction of congenital anomalies; and
- Outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth.

- **Outpatient intensity-modulated radiation therapy (IMRT) –** Prior approval is required for all outpatient IMRT services except IMRT related to the treatment of head, neck, breast, prostate or anal cancer. Brain cancer is not considered a form of head or neck cancer; therefore, prior approval is required for IMRT treatment of brain cancer.

- **Hospice care –** Prior approval is required for home hospice, continuous home hospice, or inpatient hospice care services. We will advise you which home hospice care agencies we have approved. See page 90 for information about the exception to this requirement.

- **Organ/tissue transplants –** See pages 72-72 for the list of covered organ/tissue transplants. **Prior approval is required for** both the procedure and the facility. If you travel to a Blue Distinction Center for Transplants, prior approval is also required for travel benefits (see page 77). Contact us at the customer service number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination. We will consider whether the facility is approved for the procedure and whether you meet the facility's criteria.

  The **organ transplant procedures** listed on page 71 must be performed in a facility with a Medicare-Approved Transplant Program for the type of transplant anticipated. Transplants involving more than one organ must be performed in a facility that offers a Medicare-Approved Transplant Program for each organ transplanted. Medicare's approved programs are listed at: www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/downloads/ApprovedTransplantPrograms.pdf.

  If Medicare does not offer an approved program for a certain type of organ transplant procedure, this requirement does not apply and you may use any covered facility that performs the procedure. If Medicare offers an approved program for an anticipated organ transplant, but your facility is not approved by Medicare for the procedure, please contact your Local Plan at the customer service number appearing on the back of your ID card.

  The blood or marrow stem cell transplants listed on pages 72-74 must be performed in a facility with a transplant program accredited by the Foundation for the Accreditation of Cellular Therapy (FACT), or in a facility designated as a Blue Distinction Center for Transplants or as a Cancer Research Facility. The **transplant procedures listed on page 75** must be performed at a FACT-accredited facility. See page 20 for more information about these types of facilities.

  Not every facility provides transplant services for every type of transplant procedure or condition listed, or is designated or accredited for every covered transplant. Benefits are not provided for a covered transplant procedure unless the facility is specifically designated or accredited to perform that procedure. Before scheduling a transplant, call your Local Plan at the customer service number appearing on the back of your ID card for assistance in locating an eligible facility and requesting prior approval for transplant services.

- **Clinical trials for certain blood or marrow stem cell transplants –** See pages 74 and 75 for the list of conditions covered **only** in clinical trials. Contact us at the customer service number on the back of your ID card for information or to request prior approval before obtaining services. We will request the medical evidence we need to make our coverage determination.

  Note: For the purposes of the blood or marrow stem cell clinical trial transplants covered under this Plan, a clinical trial is a research study whose protocol has been reviewed and approved by the Institutional Review Board (IRB) of the FACT-accredited facility, Blue Distinction Center for Transplants, or Cancer Research Facility (see page 20) where the procedure is to be performed.

- **Prescription drugs and supplies – Certain prescription drugs and supplies require prior approval.** Contact CVS Caremark, our Pharmacy Program administrator, at 1-800-624-5060 (TDD: 1-800-624-5077 for the hearing impaired) to request prior approval, or to obtain a list of drugs and supplies that require prior approval. We will request the information we need to make our coverage determination. You must periodically renew prior approval for certain drugs. See page 105 for more about our prescription drug prior approval program, which is part of our Patient Safety and Quality Monitoring (PSQM) program.

  Please note that updates to the list of drugs and supplies requiring prior approval are made periodically during the year. New drugs and supplies may be added to the list and prior approval criteria may change. Changes to the prior approval list or to prior approval criteria are not considered benefit changes.

  Note: Until we approve them, you must pay for these drugs in full when you purchase them – even if you purchase them at a Preferred retail pharmacy or through our specialty drug pharmacy – and submit the expense(s) to us on a claim form. Preferred pharmacies will not file these claims for you.

  Standard Option members may use our Mail Service Prescription Drug Program to fill their prescriptions. **Basic Option** members with primary Medicare Part B coverage also may use this program once prior approval is obtained.

  Note: The Mail Service Prescription Drug Program will not fill your prescription until you have obtained prior approval. CVS Caremark, the program administrator, will hold your prescription for you up to 30 days. If prior approval is not obtained within 30 days, your prescription will be returned to you along with a letter explaining the prior approval procedures.

- **Surgery by Non-participating providers under Standard Option**

You may request prior approval and receive specific benefit information in advance for non-emergency surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. When you contact your local Blue Cross and Blue Shield Plan before your surgery, the Local Plan will review your planned surgery to determine your coverage, the medical necessity of the procedure(s), and the Plan allowance for the services. You can call your Local Plan at the customer service number on the back of your ID card.

Note: Standard Option members are not required to obtain prior approval for surgeries performed by Non-participating providers (unless the surgery is listed on page 22 or is one of the transplant procedures listed on pages 71-77) – even if the charge will be $5,000 or more. If you do not call your Local Plan in advance of the surgery, we will review your claim to provide benefits for the services in accordance with the terms of your coverage.

How to request precertification for an admission or get prior approval for *Other services*

First, you, your representative, your physician, or your hospital, residential treatment center or other covered inpatient facility must call us at the telephone number listed on the back of your Service Benefit Plan ID card any time prior to admission or before receiving services that require prior approval.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, and phone number;
- reason for inpatient admission, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility;
- number of days requested for hospital stay;
- any other information we may request related to the services to be provided; and
- if the admission is to a residential treatment center, a preliminary treatment and discharge plan agreed to by the member, provider and case manager at the Local Plan, and the RTC.

  Note: You must enroll and participate in case management with your Local Plan prior to, during, and following an inpatient RTC stay. See pages 88 and 100 for additional information.

- **Non-urgent care claims**

For non-urgent care claims (including non-urgent concurrent care claims), we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for *Other services* that must have prior approval. We will notify you of our decision within 15 days after the receipt of the pre-service claim.

If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an **urgent care claim** (i.e., when waiting for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review of the claim and notify you of our decision within 72 hours as long as we receive sufficient information to complete the review. (For concurrent care claims that are also urgent care claims, please see *If your treatment needs to be extended* on page 26.) If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at the telephone number listed on the back of your Service Benefit Plan ID card. You may also call OPM's Health Insurance 1 at (202) 606-0727 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at the telephone number listed on the back of your ID card. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the request.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital. If you do not telephone us within two business days, a $500 penalty may apply – see *Warning* under *Inpatient hospital admissions* earlier in this Section and *If your facility stay needs to be extended* on page 26.

Admissions to residential treatment centers do not qualify as emergencies.

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

- **If your facility stay needs to be extended**

If your **hospital** stay – including for maternity care – needs to be extended, you, your representative, your physician, or the hospital must ask us to approve the additional days. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then:

- for the part of the admission that was medically necessary, we will pay inpatient benefits, but
- for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and we will not pay inpatient benefits.

If your **residential treatment center** stay needs to be extended, you, your representative, your physician or the residential treatment center must ask us to approve the additional days. If you remain in the residential treatment center beyond the number of days approved and did not get the additional days precertified, we will provide benefits for medically necessary covered services, other than room and board and inpatient physician care, at the level we would have paid if they had been provided on an outpatient basis.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of *Other services*, you may request a review by following the procedures listed below. Note that these procedures apply to requests for reconsideration of concurrent care claims as well (see page 25 for definition). (If you have already received the service, supply, or treatment, then your claim is a **post-service claim** and you must follow the entire disputed claims process detailed in Section 8.)

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

1. Precertify your inpatient admission or, if applicable, approve your request for prior approval for the service, drug, or supply; or
2. Write to you and maintain our denial; or
3. Ask you or your provider for more information.

   You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

   If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for your covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Note: You may have to pay the deductible, coinsurance, and/or copayment amount(s) that apply to your care at the time you receive the services.

Copayment

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: If you have Standard Option when you see your Preferred physician, you pay a copayment of $25 for the office visit, and we then pay the remainder of the amount we allow for the office visit. (You may have to pay separately for other services you receive while in the physician's office.) When you go into a Preferred hospital, you pay a copayment of $350 per admission. We then pay the remainder of the amount we allow for the covered services you receive.

Copayments do not apply to services and supplies that are subject to a deductible and/or coinsurance amount.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than your copayment, you pay the lower amount.

Note: When multiple copayment services are performed by the same professional or facility provider on the same day, only one copayment applies per provider per day. When the copayment amounts are different, the highest copayment is applicable. You may be responsible for a separate copayment for some services.

Example: If you have Basic Option when you visit the outpatient department of a Preferred hospital for non-emergency treatment services, your copayment is $100 (see page 83). If you also receive an ultrasound in the outpatient department of the same hospital on the same day, you will not be responsible for the $40 copayment for the ultrasound (shown on page 85).

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward your deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply that you then pay counts toward meeting your deductible.

Under Standard Option, the calendar year deductible is $350 per person. After the deductible amount is satisfied for an individual, covered services are payable for that individual. Under a Self Plus One enrollment, both family members must meet the individual deductible. Under a Self and Family enrollment, an individual may meet the individual deductible, or all family members' individual deductibles are considered to be satisfied when the family members' deductibles are combined and reach $700.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your Standard Option calendar year deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your Standard Option calendar year deductible ($270) has been satisfied.

Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Under Basic Option, there is **no calendar year deductible**.

Coinsurance

Coinsurance is the percentage of the Plan allowance that you must pay for your care. Your coinsurance is based on the Plan allowance, or billed amount, whichever is less. **Under Standard Option only,** coinsurance does not begin until you have met your calendar year deductible.

Example: You pay 15% of the Plan allowance under Standard Option for durable medical equipment obtained from a Preferred provider, after meeting your $350 calendar year deductible.

If your provider routinely waives your cost

Note: **If your provider routinely waives** (does not require you to pay) your applicable deductible (under Standard Option only), coinsurance, or copayments, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

Example: If your physician ordinarily charges $100 for a service but routinely waives your 35% Standard Option coinsurance, the actual charge is $65. We will pay $42.25 (65% of the actual charge of $65).

Waivers

In some instances, a Preferred, Participating, or Member provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Local Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at the customer service number on the back of your ID card.

Differences between our allowance and the bill

Our "**Plan allowance**" is the amount we use to calculate our payment for certain types of covered services. Fee-for-service plans arrive at their allowances in different ways, so allowances vary. For information about how we determine our Plan allowance, see the definition of *Plan allowance* in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. It is possible for a provider's bill to exceed the plan's allowance by a significant amount. Whether or not you have to pay the difference between our allowance and the bill will depend on the type of provider you use. Providers that have agreements with this Plan are Preferred or Participating and will not bill you for any balances that are in excess of our allowance for covered services. See the descriptions appearing below for the types of providers available in this Plan.

- **Preferred providers.** These types of providers have agreements with the Local Plan to limit what they bill our members. Because of that, when you use a Preferred provider, your share of the provider's bill for covered care is limited.

  Under Standard Option, your share consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a Preferred physician who charges $250, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 15% of our $100 allowance ($15). Because of the agreement, your Preferred physician will not bill you for the $150 difference between our allowance and his/her bill.

  Under Basic Option, your share consists only of your copayment or coinsurance amount, since there is no calendar year deductible. Here is an example involving a copayment: You see a Preferred physician who charges $250 for covered services subject to a $30 copayment. Even though our allowance may be $100, you still pay just the $30 copayment. Because of the agreement, your Preferred physician will not bill you for the $220 difference between your copayment and his/her bill.

  Remember, under Basic Option, you must use Preferred providers in order to receive benefits. See page 21 for the exceptions to this requirement.

- **Participating providers.** These types of **Non-preferred providers** have agreements with the Local Plan to limit what they bill our **Standard Option** members.

  Under Standard Option, when you use a Participating provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example: You see a Participating physician who charges $250, but the Plan allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 35% of our $100 allowance ($35). Because of the agreement, your Participating physician will not bill you for the $150 difference between our allowance and his/her bill.

  Under Basic Option, there are no benefits for care performed by Participating providers; you pay all charges. See page 21 for the exceptions to this requirement.

- **Non-participating providers.** These **Non-preferred providers** have no agreement to limit what they will bill you. As a result, your share of the provider's bill could be significantly more than what you would pay for covered care from a Preferred provider. If you plan to use a Non-participating provider for your care, we encourage you to ask the provider about the expected costs and visit our website, www.fepblue.org, or call us at the customer service number on the back of your ID card for assistance in estimating your total out-of-pocket expenses.

  Under Standard Option, when you use a Non-participating provider, you will pay your deductible and coinsurance – **plus** any difference between our allowance and the charges on the bill (except in certain circumstances – see pages 148-150). For example, you see a Non-participating physician who charges $250. The Plan allowance is again $100, and you have met your deductible. You are responsible for your coinsurance, so you pay 35% of the $100 Plan allowance or $35. Plus, because there is no agreement between the Non-participating physician and us, the physician can bill you for the $150 difference between our allowance and his/her bill. This means you would pay a total of $185 ($35 + $150) for the Non-participating physician's services, rather than $15 for the same services when performed by a Preferred physician. We encourage you to **always visit Preferred providers for your care**. **Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive.**

  Under Basic Option, there are no benefits for care performed by Non-participating providers; you pay all charges. See page 21 for the exceptions to this requirement.

The tables appearing below illustrate how much **Standard Option** members have to pay out-of-pocket for services performed by Preferred providers, Participating/Member providers, and Non-participating/Non-member providers. The first example shows services provided by a physician and the second example shows facility care billed by an ambulatory surgical facility. In both examples, your calendar year deductible has already been met. **Use this information for illustrative purposes only.**

Basic Option benefit levels for physician care begin on page 38; see page 83 for Basic Option benefit levels that apply to outpatient hospital or ambulatory surgical facility care.

In the following example, we compare how much you have to pay out-of-pocket for services provided by a Preferred physician, a Participating physician, and a Non-participating physician. The table uses our example of a service for which the physician charges $250 and the Plan allowance is $100.

EXAMPLE	Preferred Physician Standard Option		Participating Physician Standard Option		Non-participating Physician Standard Option	
Physician's charge		$250		$250		$250
Our allowance	We set it at:	100	We set it at:	100	We set it at:	100
We pay	85% of our allowance:	85	65% of our allowance:	65	65% of our allowance:	65
You owe: Coinsurance	15% of our allowance:	15	35% of our allowance:	35	35% of our allowance:	35
You owe: Copayment	Not applicable		Not applicable		Not applicable	
+ Difference up to charge?	No:	0	No:	0	Yes:	150
TOTAL YOU PAY		**$15**		**$35**		**$185**

Note: If you had not met any of your **Standard Option** deductible in the above example, only our allowance ($100), which you would pay in full, would count toward your deductible.

In the following example, we compare how much you have to pay out-of-pocket for services billed by a Preferred, Member, and Non-member ambulatory surgical facility for facility care associated with an outpatient surgical procedure. The table uses an example of services for which the ambulatory surgical facility charges $5,000. The Plan allowance is $2,900 when the services are provided at a Preferred or Member facility, and the Plan allowance is $2,500 when the services are provided at a Non-member facility.

EXAMPLE	Preferred Ambulatory Surgical Facility Standard Option		Member Ambulatory Surgical Facility Standard Option		Non-member Ambulatory Surgical Facility* Standard Option	
Facility's charge		$5,000		$5,000		$5,000
Our allowance	We set it at:	2,900	We set it at:	2,900	We set it at:	2,500
We pay	85% of our allowance:	2,465	65% of our allowance:	1,885	65% of our allowance:	1,625
You owe: Coinsurance	15% of our allowance:	435	35% of our allowance:	1,015	35% of our allowance:	875
You owe: Copayment	Not applicable		Not applicable		Not applicable	
+ Difference up to charge?	No:	0	No:	0	Yes:	2,500
TOTAL YOU PAY		**$435**		**$1,015**		**$3,375**

Note: If you had not met any of your **Standard Option** deductible in the above example, $350 of our allowed amount would be applied to your deductible before your coinsurance amount was calculated.

***A Non-member facility may bill you any amount for the services it provides. You are responsible for paying all expenses over our allowance, regardless of the total amount billed, in addition to your calendar year deductible and coinsurance. For example, if you use a Non-member facility that charges $60,000 for facility care related to outpatient bariatric surgery, and we pay the $1,625 amount illustrated above, you would owe $58,375 ($60,000 - $1,625 = $58,375). This example assumes your calendar year deductible has been met.**

Important notice about Non-participating providers!

Preferred hospitals and other covered facilities may contract with Non-participating providers to provide certain medical or surgical services at their facilities. Non-participating providers have no agreements with your Local Plan to limit what they can bill you. Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive.

Here is an example: You have coverage under Standard Option and go into a Preferred hospital for surgery. During surgery, you receive the services of a Non-participating anesthesiologist. Under Standard Option, members pay 15% of the Non-participating Provider Allowance plus any difference between that allowance and the amount billed (after the member's $350 calendar year deductible has been satisfied), for services provided in Preferred facilities by Non-participating anesthesiologists (see page 65). For Preferred provider services, members pay only a coinsurance amount of 15% of the Preferred Provider Allowance after meeting the $350 calendar year deductible.

In this example, the Non-participating anesthesiologist charges $1,200 for his/her services. Our Non-participating Provider Allowance for those services is $400. For the Non-preferred anesthesiologist's services, you would be responsible for paying 15% of the allowance ($60), plus the $800 difference between the allowance and the amount billed, for a total of $860. If you instead received services from a Preferred anesthesiologist, you would pay only 15% of the $400 allowance (after meeting your deductible), or $60, resulting in a savings to you of $800 ($860 - $60 = $800).

Always request Preferred providers for your care. Call your Local Plan at the number listed on the back of your ID card or go to our website, www.fepblue.org, to check the contracting status of your provider or to locate a Preferred provider near you.

Under Basic Option, there are no benefits for care performed by Participating/Member or Non-participating/Non-member providers. You must use Preferred providers in order to receive benefits. See page 21 for the exceptions to this requirement.

Your costs for other care

- **Overseas care. Under Standard and Basic Options,** we pay overseas claims at Preferred benefit levels. In most cases, our Plan allowance for professional provider services is based on our Overseas Fee Schedule. Most overseas professional providers are under no obligation to accept our allowance, and you must pay any difference between our payment and the provider's bill. For facility care you receive overseas, we provide benefits in full after you pay the applicable copayment or coinsurance (and, under Standard Option, any deductible amount that may apply). See Section 5(i) for more information about our overseas benefits.
- **Dental care. Under Standard Option,** we pay scheduled amounts for covered dental services and you pay balances as described in Section 5(g). **Under Basic Option,** you pay $30 for any covered evaluation and we pay the balance for covered services. **Basic Option members** must use **Preferred** dentists in order to receive benefits. See Section 5(g) for a listing of covered dental services and additional payment information.
- **Inpatient facility care. Under Standard and Basic Options,** you pay the coinsurance or copayment amounts listed in Section 5(c). **Under Standard Option,** you must meet your deductible before we begin providing benefits for certain facility-billed services. **Under Basic Option,** you must use **Preferred** facilities in order to receive benefits. See page 21 for the exceptions to this requirement.

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

Under Standard and Basic Options, we limit your annual out-of-pocket expenses for the covered services you receive to protect you from unexpected health care costs. When your eligible out-of-pocket expenses reach this catastrophic protection maximum, you no longer have to pay the associated cost-sharing amounts for the rest of the calendar year. For Self Plus One and Self and Family enrollments, once any individual family member reaches the Self Only catastrophic protection out-of-pocket maximum during the calendar year, that member's claims will no longer be subject to associated cost-sharing amounts for the rest of the year. All other family members will be required to meet the balance of the catastrophic protection out-of-pocket maximum.

Note: Certain types of expenses do not accumulate to the maximum.

Standard Option maximums:

- **Preferred Provider maximum –** For a Self Only enrollment, your out-of-pocket maximum for your deductible, and for eligible coinsurance and copayment amounts, is $5,000 when you use Preferred providers. For a Self Plus One or Self and Family enrollment, your out-of-pocket maximum for these types of expenses is $10,000 for Preferred provider services. Only eligible expenses for Preferred provider services count toward these limits.
- **Non-preferred Provider maximum –** For a Self Only enrollment, your out-of-pocket maximum for your deductible, and for eligible coinsurance and copayment amounts, is $7,000 when you use Non-preferred providers. For a Self Plus One or Self and Family enrollment, your out-of-pocket maximum for these types of expenses is $14,000 for Non-preferred provider services. For either enrollment type, eligible expenses for the services of Preferred providers also count toward these limits.

Basic Option maximum:

- **Preferred Provider maximum –** For a Self Only enrollment, your out-of-pocket maximum for eligible coinsurance and copayment amounts, is $5,500 when you use Preferred providers. For a Self Plus One or a Self and Family enrollment, your out-of-pocket maximum for these types of expenses is $11,000 when you use Preferred providers. Only eligible expenses for Preferred provider services count toward these limits.

The following expenses are not included under this feature. These expenses do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay them even after your expenses exceed the limits described above.

- The difference between the Plan allowance and the billed amount. See pages 28-29;
- Expenses for services, drugs, and supplies in excess of our maximum benefit limitations;
- Under Standard Option, your 35% coinsurance for inpatient care in a Non-member hospital;
- Under Standard Option, your 35% coinsurance for outpatient care by a Non-member facility;
- Your expenses for dental services in excess of our fee schedule payments under Standard Option. See Section 5(g);
- The $500 penalty for failing to obtain precertification, and any other amounts you pay because we reduce benefits for not complying with our cost containment requirements; and
- Under Basic Option, your expenses for care received from Participating/Non-participating professional providers or Member/Non-member facilities, except for coinsurance and copayments you pay in those situations where we do pay for care provided by Non-preferred providers. Please see page 21 for the exceptions to the requirement to use Preferred providers.

Carryover

Note: If you change to another plan during Open Season, we will continue to provide benefits between January 1 and the effective date of your new plan.

- If you had already paid the out-of-pocket maximum, we will continue to provide benefits as described on page 32 and on this page until the effective date of your new plan.
- If you had not yet paid the out-of-pocket maximum, we will apply any expenses you incur in January (before the effective date of your new plan) to our prior year's out-of-pocket maximum. Once you reach the maximum, you do not need to pay our deductibles, copayments, or coinsurance amounts (except as shown on page 32 and on this page) from that point until the effective date of your new plan.

Note: Because benefit changes are effective January 1, we will apply our next year's benefits to any expenses you incur in January.

Note: If you change options in this Plan during the year, we will credit the amounts already accumulated toward the catastrophic protection out-of-pocket limit of your old option to the catastrophic protection out-of-pocket limit of your new option. If you change from Self Only to Self Plus One or Self and Family, or vice versa, during the calendar year, please call us about your out-of-pocket accumulations and how they carry over.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

Note: We will generally first seek recovery from the provider if we paid the provider directly, or from the person (covered family member, guardian, custodial parent, etc.) to whom we sent our payment.

Note: If we provided coverage in error, but in good faith, for prescription drugs purchased through one of our pharmacy programs, we will request reimbursement from the member.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Standard and Basic Option Benefits

See pages 15-17 for how our benefits changed this year. Pages 156-157 and pages 158-159 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Standard and Basic Option Overview

This Plan offers both a Standard and Basic Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Standard and Basic Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Standard and Basic Option benefits, contact us at the customer service telephone number on the back of your Service Benefit Plan ID card or on our website at www.fepblue.org.

Each option offers unique features.

Standard Option

When you have Standard Option, you can use both Preferred and Non-preferred providers. However, your out-of-pocket expenses are lower when you use Preferred providers and Preferred providers will submit claims to us on your behalf. Standard Option has a calendar year deductible for some services and a $25 copayment for office visits to primary care providers ($35 for specialists). Standard Option also features a Preferred Retail Pharmacy Program, a Preferred Mail Service Prescription Drug Program, and a Preferred Specialty Drug Pharmacy Program.

Basic Option

Basic Option does not have a calendar year deductible. Most services are subject to copayments ($30 for primary care providers and $40 for specialists). Members do not need to have referrals to see specialists. You must use Preferred providers for your care to be eligible for benefits, except in certain circumstances, such as emergency care. Preferred providers will submit claims to us on your behalf. Basic Option also offers a Preferred Retail Pharmacy Program and a Preferred Specialty Drug Pharmacy Program. Members with primary Medicare Part B coverage have access to the Mail Service Prescription Drug Program.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Please refer to Section 3, *How you receive benefits,* for a list of providers we consider to be primary care providers and other health care professionals.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- We base payment on whether a facility or a health care professional bills for the services or supplies. 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 what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a physician, a physical therapist, or an outpatient facility.
- The services listed in this Section are for the charges billed by a physician or other health care professional for your medical care. See Section 5(c) for charges associated with the facility (i.e., hospital or other outpatient facility, etc.).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
  - The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment).
  - We provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our payment and the billed amount.
- **Under Basic Option,**
  - There is **no calendar year deductible**.
  - **You must use Preferred providers in order to receive benefits. See below and page 21 for the exceptions to this requirement.**
  - We provide benefits at Preferred benefit levels for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our payment and the billed amount.

Benefit Description	You Pay	
Note: **For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.**		
Diagnostic and treatment services	**Standard Option**	**Basic Option**
Outpatient professional services of physicians and other health care professionals: • Consultations • Second surgical opinions • Clinic visits • Office visits • Home visits • Initial examination of a newborn needing definitive treatment when covered under a Self Plus One or Self and Family enrollment • Pharmacotherapy (medication management) [see Section 5(f) for prescription drug coverage] ***Note:*** Please refer to pages 40-41 for our coverage of laboratory, X-ray, and other diagnostic tests billed for by a health care professional, and to pages 84-86 for our coverage of these services when billed for by a facility, such as the outpatient department of a hospital.	Preferred primary care provider or other health care professional: $25 copayment per visit (no deductible) Preferred specialist: $35 copayment per visit (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $30 copayment per visit Preferred specialist: $40 copayment per visit ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 144 for more information about "agents.") Participating/Non-participating: You pay all charges
Inpatient professional services: • During a covered hospital stay • Services for nonsurgical procedures when ordered, provided, and billed by a physician during a covered inpatient hospital admission • Medical care by the attending physician (the physician who is primarily responsible for your care when you are hospitalized) on days we pay hospital benefits ***Note:*** A consulting physician employed by the hospital is not the attending physician. • Consultations when requested by the attending physician • Concurrent care – hospital inpatient care by a physician other than the attending physician for a condition not related to your primary diagnosis, or because the medical complexity of your condition requires this additional medical care • Physical therapy by a physician other than the attending physician • Initial examination of a newborn needing definitive treatment when covered under a Self Plus One or Self and Family enrollment • Pharmacotherapy (medication management) [see Section 5(c) for our coverage of drugs you receive while in the hospital] • Second surgical opinion • Nutritional counseling when billed by a covered provider	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

Diagnostic and treatment services – continued on next page

Diagnostic and treatment services *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Not covered: • *Routine services except for those Preventive care services described on pages 42-47* • *Telephone consultations and online medical evaluation and management services* • *Private duty nursing* • *Standby physicians* • *Routine radiological and staff consultations required by facility rules and regulations* • *Inpatient physician care when your admission or portion of an admission is not covered [see Section 5(c)]* **Note:** *If we determine that an inpatient admission is not covered, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.*	*All charges*	*All charges*
Lab, X-ray, and other diagnostic tests		
Diagnostic tests limited to: • Laboratory tests (such as blood tests and urinalysis) • Pathology services • EKGs ***Note:*** See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Preferred: Nothing ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 144 for more information about "agents.") Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.

Lab, X-ray, and other diagnostic tests – continued on next page

Lab, X-ray, and other diagnostic tests *(continued)*	You Pay	
	Standard Option	**Basic Option**
Diagnostic tests including but not limited to: • Cardiovascular monitoring • EEGs • Neurological testing • Ultrasounds • X-rays (including set-up of portable X-ray equipment) ***Note:*** See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Preferred: $40 copayment ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 144 for more information about "agents.") Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount in addition to the Preferred copayment listed above.
Diagnostic tests limited to: • Bone density tests • CT scans/MRIs/PET scans • Angiographies • Genetic testing ***Note:*** Benefits are available for specialized diagnostic genetic testing when it is medically necessary to diagnose and/or manage a patient's existing medical condition. Benefits are not provided for genetic panels when some or all of the tests included in the panel are not covered, are experimental or investigational, or are not medically necessary. Refer to the next paragraph for information about diagnostic BRCA testing. ***Note:*** **You must obtain prior approval for BRCA testing (see page 22).** Diagnostic BRCA testing, including testing for large genomic rearrangements in the BRCA1 and BRCA2 genes. Benefits are available for members with a cancer diagnosis when the requirements in the note above are met, and the member does not meet criteria for Preventive BRCA testing. Benefits are limited to one test of each type per lifetime whether covered as a diagnostic test or paid under Preventive care benefits (see pages 44-45). ***Note:*** See pages 44-45 in this Section for coverage of genetic counseling and testing services related to family history of cancer or other disease. • Nuclear medicine • Sleep studies ***Note:*** See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Preferred: $100 copayment ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 144 for more information about "agents.") Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount in addition to the Preferred copayment listed above.

Preventive care, adult	You Pay	
	Standard Option	Basic Option
Benefits are provided for preventive care services for adults age 22 and over, including services recommended by the U.S. Preventive Services Task Force (USPSTF). ***Note:*** A complete list of USPSTF-recommended preventive care services is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and www.healthcare.gov/what-are-my-preventive-care-benefits. Covered services include: • Visits/exams for preventive care ***Note:*** See the definition of *Preventive care, Adult* on page 151 for included health screening services. • Individual counseling on prevention and reducing health risks ***Note:*** Preventive care benefits are not available for group counseling. ***Note:*** Preventive care benefits for each of the services listed below are limited to one per calendar year. • Chest X-ray • EKG • Urinalysis • General health panel • Basic or comprehensive metabolic panel test • CBC • Fasting lipoprotein profile (total cholesterol, LDL, HDL, and/or triglycerides) • Screening for diabetes mellitus • Screening for hepatitis B • Screening for hepatitis C • Screening for alcohol/substance abuse ***Note:*** See pages 64 and 112 for our coverage of smoking and tobacco cessation treatment. • Screening for chlamydial infection • Screening for gonorrhea infection • Screening for human papillomavirus (HPV) for females • Screening for human immunodeficiency virus (HIV) infection • Screening for syphilis infection • Administration and interpretation of a Health Risk Assessment (HRA) questionnaire (see *Definitions*) ***Note:*** As a member of the Service Benefit Plan, you have access to the Blue Cross and Blue Shield HRA, called the "Blue Health Assessment" questionnaire. Completing the questionnaire entitles you to receive special benefit incentives. See Section 5(h) for complete information.	Preferred: Nothing (no deductible) ***Note:*** If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services. Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred: Nothing ***Note:*** If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. ***Note:*** When billed by a Preferred facility, such as the outpatient department of a hospital, we provide benefits as shown here for Preferred providers. ***Note:*** Benefits are not available for visits/exams for preventive care, associated laboratory tests, colonoscopies, or routine immunizations performed at Member or Non-member facilities. ***Note:*** See Section 5(c) for our payment levels for covered cancer screenings and ultrasound screening for abdominal aortic aneurysm billed for by Member or Non-member facilities and performed on an outpatient basis.

Preventive care, adult – continued on next page

Preventive care, adult *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
• Colorectal cancer tests, including: – Fecal occult blood test – Colonoscopy, with or without biopsy (see page 66 for our payment levels for diagnostic colonoscopies) – Sigmoidoscopy – Double contrast barium enema • Prostate cancer tests – Prostate Specific Antigen (PSA) test • Cervical cancer tests (including Pap tests) • Screening mammograms ***Note:*** Preventive care benefits for each of the services listed above are limited to one per calendar year. ***Note:*** We pay preventive care benefits on the first claim we process for each of the above tests you receive in the calendar year. Regular coverage criteria and benefit levels apply to subsequent claims for those types of tests if performed in the same year. • Low-dose CT screening for lung cancer (limited to one per year, for adults age 55 to 80, with a history of tobacco use) • Osteoporosis screening for women age 65 and over or women ages 50 to 65 who are at increased risk • Ultrasound for abdominal aortic aneurysm for adults, ages 65 to 75, limited to one screening per lifetime • Nutritional counseling when billed by a covered provider ***Note:*** Benefits are limited to individual nutritional counseling services. We do not provide benefits for group counseling services. ***Note:*** If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services.	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred: Nothing Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. ***Note:*** When billed by a Preferred facility, such as the outpatient department of a hospital, we provide benefits as shown here for Preferred providers. ***Note:*** Benefits are not available for visits/exams for preventive care, associated laboratory tests, colonoscopies, or routine immunizations performed at Member or Non-member facilities. ***Note:*** See Section 5(c) for our payment levels for covered cancer screenings and ultrasound screening for abdominal aortic aneurysm billed for by Member or Non-member facilities and performed on an outpatient basis.

Preventive care, adult – continued on next page

Preventive care, adult *(continued)*	You Pay	
	Standard Option	**Basic Option**
Hereditary Breast and Ovarian Cancer Screening Benefits are available for screening members, age 18 and over, to evaluate the risk for developing certain types of hereditary breast or ovarian cancer related to mutations in BRCA1 and BRCA2 genes: • **Genetic counseling and evaluation** for members whose personal and/or family history is associated with an increased risk for harmful mutations in BRCA1 and BRCA2 genes. • **BRCA testing** for members whose personal and/or family history is associated with an increased risk for harmful mutations in BRCA1 or BRCA2 genes. ***Note:*** You must receive genetic counseling and evaluation services and obtain prior approval before you receive preventive BRCA testing. Preventive care benefits will not be provided for BRCA testing unless you receive genetic counseling and evaluation prior to the test, and scientifically valid screening measures are used for the evaluation, and the results support BRCA testing. See page 22 for information about prior approval. Eligible members must meet at least one of the following criteria: – Members who have a personal history of breast, ovarian, fallopian tube, peritoneal, pancreatic and/or prostate cancer, who have not received BRCA testing, when genetic counseling and evaluation using scientifically valid measures (see above) supports BRCA testing – Members who have not been diagnosed with breast, ovarian, fallopian tube, peritoneal, pancreatic, and/or prostate cancer who meet at least one of the following family history criteria (see below for members of Ashkenazi Jewish heritage): o Individual from a family with a known harmful mutation in BRCA1 and/or BRCA2 gene; or o Two first-degree female relatives with breast cancer, one of whom was diagnosed at age 50 or younger; or o A combination of three or more first- or second-degree female relatives with breast cancer regardless of age at diagnosis; or o A first- or second-degree relative with both breast and ovarian cancer at any age; or	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories, you pay any difference between our allowance and the billed amount. ***Note:*** When billed by a Preferred facility, such as the outpatient department of a hospital, we provide benefits as shown here for Preferred providers. Benefits are not available for BRCA testing performed at Member or Non-member facilities.

Preventive care, adult – continued on next page

Preventive care, adult *(continued)*	You Pay	
	Standard Option	Basic Option
BRCA testing *(continued from page 44)* o A history of breast cancer in a first- or second-degree female relative, and a history of ovarian, fallopian tube, or primary peritoneal cancer in the same or another female first- or second-degree relative; or o A first-degree female relative with bilateral breast cancer; or o A combination of two or more first- or second-degree female relatives with ovarian cancer regardless of age at diagnosis; or o A history of breast cancer in a male relative – Members of Ashkenazi Jewish heritage who have not been diagnosed with breast, ovarian, fallopian tube, peritoneal, pancreatic, and/or prostate cancer must meet one of the following family history criteria: o Individual from a family with a known harmful mutation in BRCA1 and/or BRCA2 gene; or o Any first-degree relative with breast or ovarian cancer; or o Two second-degree relatives on the same side of the family with breast or ovarian cancer First-degree relatives are defined as: parents, siblings, and children of the member being tested. Second-degree relatives are defined as: grandparents, aunts, uncles, nieces, nephews, grandchildren, and half-siblings (siblings with one shared biological parent) of the member being tested. Relatives may be living or deceased. • **Testing for large genomic rearrangements of the BRCA1 and BRCA2 genes** – Eligible members are age 18 or older; and – Receive genetic counseling and evaluation prior to the BRCA1 and BRCA2 testing; and – Meet BRCA testing criteria described above and on page 44. ***Note:*** Benefits for BRCA testing and testing for large genomic rearrangements of the BRCA1 and BRCA2 genes are limited to one of each type of test per lifetime whether considered a preventive screening or a diagnostic test (see page 41 for our coverage of diagnostic BRCA testing). ***Note:*** Preventive care benefits are not available for surgical removal of breasts, ovaries, or prostate.	See page 44	See page 44

Preventive care, adult – continued on next page

Preventive care, adult *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Routine immunizations [as licensed by the U.S. Food and Drug Administration (FDA)], limited to: • Hepatitis (Types A and B) for patients with increased risk or family history • Herpes zoster (shingles)* • Human papillomavirus (HPV)* • Influenza (flu)* • Measles, mumps, rubella • Meningococcal* • Pneumococcal* • Tetanus, diphtheria, pertussis booster (one every 10 yrs) • Varicella *Many Preferred retail pharmacies participate in our vaccine network. See page 108 for our coverage of these vaccines when provided by pharmacies in the vaccine network.	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** We waive your deductible and coinsurance amount for services billed by Participating/ Non-participating providers related to Influenza (flu) vaccines. If you use a Non-participating provider, you pay any difference between our allowance and the billed amount. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred: Nothing Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** We provide benefits for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. If you use a Non-participating provider, you pay any difference between our allowance and the billed amount. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.
Note: U.S. FDA licensure may restrict the use of the immunizations and vaccines listed above to certain age ranges, frequencies, and/or other patient-specific indications, including gender. ***Note:*** If you receive both preventive and diagnostic services from your Preferred provider on the same day, you are responsible for paying your cost-share for the diagnostic services. ***Note:*** See page 109 for our payment levels for medicines to promote better health as recommended under the Affordable Care Act. ***Note:*** The benefits listed above and on pages 42-45 do not apply to children up to age 22. (See benefits under *Preventive care, children*, this Section.)	See above and pages 42-45	See above and pages 42-45
Not covered: • *Genetic testing related to family history of cancer or other disease, except as described on pages 44-45* ***Note:*** *See page 41 for our coverage of medically necessary diagnostic genetic testing.* • Genetic panels when some or all of the tests included in the panel are not covered, are experimental or investigational, or are not medically necessary • *Group counseling on prevention and reducing health risks* • *Self-administered health risk assessments (other than the Blue Health Assessment)* • *Screening services requested solely by the member, such as commercially advertised heart scans, body scans, and tests performed in mobile traveling vans*	*All charges*	*All charges*

Preventive care, children	You Pay	
	Standard Option	Basic Option
Benefits are provided for preventive care services for children up to age 22, including services recommended under the Affordable Care Act (ACA), and by the American Academy of Pediatrics (AAP). ***Note:*** A complete list of preventive care services recommended by the U.S. Preventive Services Task Force (USPSTF) is available online at: www.healthcare.gov/what-are-my-preventive-care-benefits/children. Covered services include: • Healthy newborn visits and screenings (inpatient or outpatient) • Visits/exams for preventive care • Laboratory tests • Hearing and vision screenings • Application of fluoride varnish for children through age 5, when administered by a primary care provider (limited to 2 per calendar year) • Routine immunizations as licensed by the U.S. Food and Drug Administration (FDA) limited to: – Diphtheria, tetanus, pertussis – Hemophilus influenza type b (Hib) – Hepatitis (types A and B) – Human papillomavirus (HPV) – Inactivated poliovirus – Measles, mumps, rubella – Meningococcal – Pneumococcal – Rotavirus – Influenza (flu) – Varicella ***Note:*** U.S. FDA licensure may restrict the use of certain immunizations and vaccines to specific age ranges, frequencies, and/or other patient-specific indications, including gender. • Nutritional counseling services (see page 43) ***Note:*** Preventive care benefits for each of the services listed below are limited to one per calendar year. • Screening for hepatitis B for children age 13 and over • Screening for chlamydial infection • Screening for gonorrhea infection • Screening for human papillomavirus (HPV) for females • Screening for human immunodeficiency virus (HIV) infection • Screening for syphilis infection ***Note:*** See page 109 for our payment levels for medicines to promote better health as recommended under the Affordable Care Act. ***Note:*** If your child receives both preventive and diagnostic services from a Preferred provider on the same day, you are responsible for paying the cost-share for the diagnostic services.	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** We waive the deductible and coinsurance amount for services billed by Participating/ Non-participating providers related to Influenza (flu) vaccines. If you use a Non-participating provider, you pay any difference between our allowance and the billed amount. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred: Nothing Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount. ***Note:*** We provide benefits for services billed by Participating/Non-participating providers related to Influenza (flu) vaccines. If you use a Non-participating provider, you pay any difference between our allowance and the billed amount. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.

Maternity care	You Pay	
	Standard Option	Basic Option
Maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage, such as: • Prenatal care (including ultrasound, laboratory, and diagnostic tests) ***Note:*** See Section 5(h) for details about our Pregnancy Care Incentive Program. • Delivery • Postpartum care • Assistant surgeons/surgical assistance if required because of the complexity of the delivery • Anesthesia (including acupuncture) when requested by the attending physician and performed by a certified registered nurse anesthetist (CRNA) or a physician other than the operating physician (surgeon) or the assistant • Tocolytic therapy and related services when provided on an inpatient basis during a covered hospital admission • Breastfeeding education and individual coaching on breastfeeding by health care providers such as physicians, physician assistants, midwives, nurse practitioners/clinical specialists, and lactation consultants ***Note:*** See page 49 for our coverage of breast pump kits. • Mental health treatment for postpartum depression and depression during pregnancy ***Note:*** We provide benefits to cover up to 4 visits per year in full to treat depression associated with pregnancy (i.e., depression during pregnancy, postpartum depression, or both) when you use a Preferred provider. See Section 5(e) for our coverage of mental health visits to Non-preferred providers and benefits for additional mental health services. ***Note:*** See page 43 for our coverage of nutritional counseling. ***Note:*** Benefits for home nursing visits related to covered maternity care are subject to the visit limitations described on page 62. ***Note:*** Maternity Care benefits are not provided for prescription drugs required during pregnancy, except as recommended under the Affordable Care Act. See page 109 for more information. See Section 5(f) for other prescription drug coverage.	Preferred: Nothing (no deductible) ***Note:*** For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use Preferred providers. Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** You may request prior approval and receive specific benefit information in advance for the delivery itself and any other maternity-related surgical procedures to be provided by a Non-participating physician when the charge for that care will be **$5,000 or more**. Call your Local Plan at the customer service number on the back of your ID card to obtain information about your coverage and the Plan allowance for the services.	Preferred: Nothing ***Note:*** For Preferred facility care related to maternity, including care at Preferred birthing facilities, your responsibility for covered inpatient services is limited to $175 per admission. For outpatient facility services related to maternity, see page 83. Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you are responsible only for any difference between our allowance and the billed amount.

Maternity care – continued on next page

Maternity care *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 26 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary. • We cover routine nursery care of the newborn child when performed during the covered portion of the mother's maternity stay and billed by the facility. We cover other care of an infant who requires professional services or non-routine treatment, only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. ***Note:*** When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. Regular medical or surgical benefits apply rather than maternity benefits. ***Note:*** See page 66 for our payment levels for circumcision.		
• Breast pump kit, limited to one of the two kits listed below, per calendar year, for women who are pregnant and/or nursing – Ameda Manual pump kit ***or*** – Ameda Double Electric pump kit ***Note:*** The breast pump kit will include a supply of 150 Ameda milk storage bags. You may order Ameda milk storage bags, limited to 150 bags every 90 days, even if you own your own breast pump. ***Note:*** Benefits for the breast pump kit and milk storage bags are only available when you order them through CVS Caremark by calling 1-800-262-7890.	Nothing (no deductible)	Nothing

Maternity care – continued on next page

Maternity care *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
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* • *Genetic testing/screening of the baby's father (see page 41 for our coverage of medically necessary diagnostic genetic testing)* • *Childbirth preparation, Lamaze, and other birthing/parenting classes* • *Breast pumps and milk storage bags except as stated on page 49* • *Breastfeeding supplies other than those contained in the breast pump kit described on page 49 including clothing (e.g., nursing bras), baby bottles, or items for personal comfort or convenience (e.g., nursing pads)* • *Tocolytic therapy and related services provided on an outpatient basis* • *Maternity care for women not enrolled in this Plan*	*All charges*	*All charges*
Family planning		
A range of voluntary family planning services for women, limited to: • Contraceptive counseling • Diaphragms and contraceptive rings • Injectable contraceptives • Intrauterine devices (IUDs) • Implantable contraceptives • Voluntary sterilization (tubal ligation or tubal occlusion/tubal blocking procedures only) ***Note:*** See page 66 for our coverage of voluntary sterilization for men. ***Note:*** We also provide benefits for professional services associated with voluntary sterilizations and with the fitting, insertion, implantation, or removal of the contraceptives listed above at the payment levels shown here. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

Family planning – continued on next page

Family planning *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
• Oral and transdermal contraceptives ***Note:*** We waive your cost-share for generic oral and transdermal contraceptives when you purchase them at a Preferred retail pharmacy or for Standard Option members and for Basic Option members with primary Medicare Part B, through the Mail Service Prescription Drug Program. See page 107 for more information. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
Not covered: • *Reversal of voluntary surgical sterilization* • *Contraceptive devices not described above* • *Over-the-counter (OTC) contraceptives, except as described in Section 5(f)*	*All charges*	*All charges*
Reproductive services		
Diagnosis and treatment of infertility, except for the Reproductive services listed as not covered on page 50 ***Note:*** See Section 5(f) for prescription drug coverage.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $30 copayment per visit Preferred specialist: $40 copayment per visit ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 144 for more information about "agents.") Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.

Reproductive services – continued on next page

Reproductive services *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
The services listed below are not covered as treatments for infertility or as alternatives to conventional conception: • *Assisted reproductive technology (ART) and assisted insemination procedures, including but not limited to:* – *Artificial insemination (AI)* – *In vitro fertilization (IVF)* – *Embryo transfer and Gamete Intrafallopian Transfer (GIFT)* – *Zygote Intrafallopian Transfer (ZIFT)* – *Intravaginal insemination (IVI)* – *Intracervical insemination (ICI)* – *Intracytoplasmic sperm injection (ICSI)* – *Intrauterine insemination* (IUI) • *Services, procedures, and/or supplies that are related to ART and/or assisted insemination procedures* • *Cryopreservation or storage of sperm (sperm banking), eggs, or embryos* • *Preimplantation diagnosis, testing, and/or screening, including the testing or screening of eggs, sperm, or embryos* • *Drugs used in conjunction with ART and assisted insemination procedures* • *Services, supplies, or drugs provided to individuals not enrolled in this Plan*	*All charges*	*All charges*

Allergy care	You Pay	
	Standard Option	**Basic Option**
• Allergy testing • Allergy treatment • Sublingual allergy desensitization drugs as licensed by the FDA, limited to Grastek, Oralair, and Ragwitek ***Note:*** See page 39 for applicable office visit copayment.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $30 copayment Preferred specialist: $40 copayment ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 144 for more information about "agents." Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
• Allergy injections ***Note:*** See page 39 for applicable office visit copayment.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
• Preparation of each multi-dose vial of antigen ***Note:*** See page 39 for applicable office visit copayment.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $30 copayment per multi-dose vial of antigen Preferred specialist: $40 copayment per multi-dose vial of antigen Participating/Non-participating: You pay all charges (except as noted below) ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay any difference between our allowance and the billed amount.
Not covered: Provocative food testing	*All charges*	*All charges*

Treatment therapies	You Pay	
	Standard Option	Basic Option
Outpatient treatment therapies: • Chemotherapy and radiation therapy ***Note:*** We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under *Organ/tissue transplants* in Section 5(b). See also, *Other services* under *You need prior Plan approval for certain services* in Section 3 (pages 22 and 23). • Intensity-modulated radiation therapy (IMRT) ***Note:*** **You must get prior approval for outpatient IMRT related to cancers, except head, neck, breast, prostate, or anal cancer.** Please refer to page 23 for more information. • Renal dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy – Home IV or infusion therapy ***Note:*** Home nursing visits associated with Home IV/infusion therapy are covered as shown under *Home health services* on page 62. • Outpatient cardiac rehabilitation ***Note:*** See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital. ***Note:*** See page 63 for our coverage of osteopathic and chiropractic manipulative treatment.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $30 copayment per visit Preferred specialist: $40 copayment per visit ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 144 for more information about "agents.") Participating/Non-participating: You pay all charges
Inpatient treatment therapies: • Chemotherapy and radiation therapy ***Note:*** We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under *Organ/tissue transplants* in Section 5(b). See also, *Other services* under *You need prior Plan approval for certain services* in Section 3 (pages 22 and 23). • Renal dialysis – Hemodialysis and peritoneal dialysis • Pharmacotherapy (medication management) [see Section 5(c) for our coverage of drugs administered in connection with these treatment therapies]	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

Physical therapy, occupational therapy, speech therapy, and cognitive therapy	You Pay	
	Standard Option	**Basic Option**
• Physical therapy, occupational therapy, and speech therapy • Cognitive rehabilitation therapy ***Note:*** When billed by a skilled nursing facility, nursing home, extended care facility, or residential treatment center, we pay benefits as shown here for professional care, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $25 copayment per visit (no deductible) Preferred specialist: $35 copayment per visit (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** Benefits are limited to 75 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three. ***Note:*** Visits that you pay for while meeting your calendar year deductible count toward the limit cited above. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $30 copayment per visit Preferred specialist: $40 copayment per visit ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 144 for more information about "agents.") ***Note:*** Benefits are limited to 50 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three. Participating/Non-participating: You pay all charges ***Note:*** See Section 5(c) for our payment levels for rehabilitative therapies billed for by the outpatient department of a hospital.
Not covered: • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Maintenance or palliative rehabilitative therapy* • *Exercise programs* • *Hippotherapy (exercise on horseback)* • *Massage therapy* • *Applied behavior analysis (ABA) or ABA therapy*	*All charges*	*All charges*

Hearing services (testing, treatment, and supplies)	You Pay	
	Standard Option	**Basic Option**
• Hearing tests related to illness or injury • Testing and examinations for prescribing hearing aids ***Note:*** For our coverage of hearing aids and related services, see page 59.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $30 copayment per visit Preferred specialist: $40 copayment per visit ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 144 for more information about "agents.") Participating/Non-participating: You pay all charges
Not covered: • *Routine hearing tests (except as indicated on page 47)* • *Hearing aids (except as described on page 59)*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)		
Benefits are limited to one pair of eyeglasses, replacement lenses, or contact lenses per incident prescribed: • To correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery; • If the condition can be corrected by surgery, but surgery is not an appropriate option due to age or medical condition; • For the nonsurgical treatment for amblyopia and strabismus, for children from birth through age 18 ***Note:*** Benefits are provided for refractions only when the refraction is performed to determine the prescription for the one pair of eyeglasses, replacement lenses, or contact lenses provided per incident as described above.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Vision services (testing, treatment, and supplies) – continued on next page

Vision services (testing, treatment, and supplies) *(continued)*	You Pay	
	Standard Option	**Basic Option**
• Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 18 ***Note:*** See page 56 for our coverage of eyeglasses, replacement lenses, or contact lenses when prescribed as nonsurgical treatment for amblyopia and strabismus. ***Note:*** See Section 5(b), *Surgical procedures*, for coverage for surgical treatment of amblyopia and strabismus. ***Note:*** See pages 40-41 in this Section for our payment levels for Lab, X-ray, and other diagnostic tests performed or ordered by your provider. Benefits are not available for refractions except as described on page 56.	Preferred primary care provider or other health care professional: $25 copayment (no deductible) Preferred specialist: $35 copayment (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $30 copayment per visit Preferred specialist: $40 copayment per visit ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 144 for more information about "agents.") Participating/Non-participating: You pay all charges
Not covered: • *Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as described on page 56* • *Deluxe eyeglass frames or lens features for eyeglasses or contact lenses such as special coating, polarization, UV treatment, etc.* • *Multifocal, accommodating, toric, or other premium intraocular lenses (IOLs) including Crystalens, ReStor, and ReZoom* • *Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described above* • *LASIK, INTACS, radial keratotomy, and other refractive surgical services* • *Refractions, including those performed during an eye examination related to a specific medical condition, except as described on page 56*	*All charges*	*All charges*

Foot care	You Pay	
	Standard Option	**Basic Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes ***Note:*** See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts. ***Note:*** See Section 5(b) for our coverage for surgical procedures.	Preferred primary care provider or other health care professional: $25 copayment for the office visit (no deductible); 15% of the Plan allowance for all other services (deductible applies) Preferred specialist: $35 copayment for the office visit (no deductible); 15% of the Plan allowance for all other services (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $30 copayment per visit Preferred specialist: $40 copayment per visit ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 144 for more information about "agents.") Participating/Non-participating: You pay all charges
Not covered: Routine foot care, such as cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above	*All charges*	*All charges*
Orthopedic and prosthetic devices		
Orthopedic braces and prosthetic appliances such as: • Artificial limbs and eyes • Functional foot orthotics when prescribed by a physician • Rigid devices attached to the foot or a brace, or placed in a shoe • Replacement, repair, and adjustment of covered devices • Following a mastectomy, breast prostheses and surgical bras, including necessary replacements • Surgically implanted penile prostheses to treat erectile dysfunction ***Note:*** A **prosthetic appliance** is a device that is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body. We provide hospital benefits for internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b).	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges

Orthopedic and prosthetic devices – continued on next page

Orthopedic and prosthetic devices *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
• Hearing aids for children up to age 22, limited to $2,500 per calendar year • Hearing aids for adults age 22 and over, limited to $2,500 every 3 calendar years ***Note:*** Benefits for hearing aid dispensing fees, fittings, batteries, and repair services are included in the benefit limits described above.	Any amount over $2,500 (no deductible)	Any amount over $2,500
• Bone anchored hearing aids when medically necessary for members with traumatic injury or malformation of the external ear or middle ear (such as a surgically induced malformation or congenital malformation), limited to $5,000 per calendar year	Any amount over $5,000 (no deductible)	Any amount over $5,000
• Wigs for hair loss due to the treatment of cancer ***Note:*** Benefits for wigs are paid at 100% of the billed amount, limited to $350 for one wig per lifetime.	Any amount over $350 for one wig per lifetime (no deductible)	Any amount over $350 for one wig per lifetime
Not covered: • *Shoes (including diabetic shoes)* • *Over-the-counter orthotics* • *Arch supports* • *Heel pads and heel cups* • *Wigs (including cranial prostheses), except for scalp hair prosthesis for hair loss due to the treatment of cancer, as stated above* • *Hearing aid accessories or supplies (including remote controls and warranty packages)* • *Orthopedic and prosthetic devices, including penile prostheses, for the treatment of gender identity/gender dysphoria*	*All charges*	*All charges*

Durable medical equipment (DME)	You Pay	
	Standard Option	**Basic Option**
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Home dialysis equipment • Oxygen equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Continuous passive motion (CPM) devices • Dynamic orthotic cranioplasty (DOC) devices • Insulin pumps • Other items that we determine to be DME, such as compression stockings ***Note:*** We cover DME at Preferred benefit levels only when you use a Preferred DME provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred DME providers.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** See Section 5(c) for our coverage of DME provided and billed by a facility.	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges ***Note:*** See Section 5(c) for our coverage of DME provided and billed by a facility.
• Speech-generating devices, limited to $1,250 per calendar year	Any amount over $1,250 per year (no deductible)	Any amount over $1,250 per year

Durable medical equipment (DME) – continued on next page

Durable medical equipment (DME) *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Not covered: • *Exercise and bathroom equipment* • *Vehicle modifications, replacements, or upgrades* • *Home modifications, upgrades, or additions* • *Lifts, such as seat, chair, or van lifts* • *Car seats* • *Diabetic supplies, except as described in Section 5(f) or when Medicare Part B is primary* • *Air conditioners, humidifiers, dehumidifiers, and purifiers* • *Breast pumps, except as described on page 49* • *Communications equipment, devices, and aids (including computer equipment) such as "story boards" or other communication aids to assist communication-impaired individuals (except for speech-generating devices as listed on page 60)* • *Equipment for cosmetic purposes* • *Topical Hyperbaric Oxygen Therapy (THBO)*	*All charges*	*All charges*
Medical supplies		
• Medical foods for children with inborn errors of amino acid metabolism • Medical foods and nutritional supplements when administered by catheter or nasogastric tubes • Medical foods, as defined by the U.S. Food and Drug Administration, that are administered orally and that provide the sole source (100%) of nutrition, for children up to age 22, for up to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate) ***Note:*** See Section 10, *Definitions*, for more information about medical foods. • Ostomy and catheter supplies • Oxygen ***Note:*** When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for oxygen, according to the contracting status of the facility. • Blood and blood plasma, except when donated or replaced, and blood plasma expanders ***Note:*** We cover medical supplies at Preferred benefit levels only when you use a Preferred medical supply provider. Preferred physicians, facilities, and pharmacies are not necessarily Preferred medical supply providers.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
Not covered: • *Infant formulas used as a substitute for breastfeeding* • *Diabetic supplies, except as described in Section 5(f) or when Medicare Part B is primary*	*All charges*	*All charges*

Home health services	You Pay	
	Standard Option	**Basic Option**
Home nursing care for two hours per day when: • A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and • A physician orders the care	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** Benefits for home nursing care are limited to 50 visits per person, per calendar year. ***Note:*** Visits that you pay for while meeting your calendar year deductible count toward the annual visit limit.	Preferred: $30 copayment per visit ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 144 for more information about "agents.") ***Note:*** Benefits for home nursing care are limited to 25 visits per person, per calendar year. Participating/Non-participating: You pay all charges
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for bathing, feeding, exercising, moving the patient, homemaking, giving medication, or acting as a companion or sitter* • *Services provided by a nurse, nursing assistant, health aide, or other similarly licensed or unlicensed person that are billed by a skilled nursing facility, extended care facility, or nursing home, except as included in the benefits described on page 89* • *Private duty nursing*	*All charges*	*All charges*

Manipulative treatment	You Pay	
	Standard Option	Basic Option
Manipulative treatment performed by a Doctor of Osteopathy (D.O.), Doctor of Medicine (M.D.), or Doctor of Chiropractic (D.C.) when the provider is practicing within the scope of his/her license, limited to: • Osteopathic manipulative treatment to any body region • Chiropractic spinal and/or extraspinal manipulative treatment ***Note:*** Benefits for manipulative treatment are limited to the services and combined treatment visits stated here.	Preferred: $25 copayment per visit (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** Benefits for osteopathic and chiropractic manipulative treatment are limited to a combined total of 12 visits per person, per calendar year. ***Note:*** Manipulation visits that you pay for while meeting your calendar year deductible count toward the treatment limit cited above.	Preferred: $30 copayment per visit ***Note:*** Benefits for osteopathic and chiropractic manipulative treatment are limited to a combined total of 20 visits per person, per calendar year. Participating/Non-participating: You pay all charges
Alternative treatments		
Acupuncture ***Note:*** Acupuncture must be performed and billed by a health care provider who is licensed or certified to perform acupuncture by the state where the services are provided, and who is acting within the scope of that license or certification. See page 18 for more information. ***Note:*** See page 78 for our coverage of acupuncture when provided as anesthesia for covered surgery. ***Note:*** See page 48 for our coverage of acupuncture when provided as anesthesia for covered maternity care.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** Benefits for acupuncture are limited to 24 visits per calendar year. ***Note:*** Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.	Preferred primary care provider or other health care professional: $30 copayment per visit Preferred specialist: $40 copayment per visit ***Note:*** Benefits for acupuncture are limited to 10 visits per calendar year. ***Note:*** You pay 30% of the Plan allowance for drugs and supplies. Participating/Non-participating: You pay all charges
Not covered: • *Biofeedback* • *Self-care or self-help training*	*All charges*	*All charges*

Educational classes and programs	You Pay	
	Standard Option	Basic Option
• Smoking and tobacco cessation treatment • Individual counseling for smoking and tobacco use cessation ***Note:*** Benefits are not available for group counseling. • Smoking and tobacco cessation classes ***Note:*** See Section 5(f) for our coverage of smoking and tobacco cessation drugs.	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
• Diabetic education ***Note:*** See pages 39 and 43 for our coverage of nutritional counseling services that are not part of a diabetic education program.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $30 copayment per visit Preferred specialist: $40 copayment per visit Participating/Non-participating: You pay all charges
Not covered: • *Marital, family, educational, or other counseling or training services when performed as part of an educational class or program* • *Premenstrual syndrome (PMS), lactation (except as described on page 48), headache, eating disorder (except as described on pages 39 and 43), and other educational clinics* • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Services performed or billed by a school or halfway house or a member of its staff* • *Applied behavior analysis (ABA) or ABA therapy*	*All charges*	*All charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- We base payment on whether a facility or a health care professional bills for the services or supplies. 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 what type of provider bills for the service.
- The services listed in this Section are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL for the following surgical services if they are to be performed on an outpatient basis: surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 22 for more information.**
- **YOU MUST GET PRIOR APPROVAL for all organ transplant surgical procedures (except kidney and cornea transplants); and if your surgical procedure requires an inpatient admission, YOU MUST GET PRECERTIFICATION. Please refer to the prior approval and precertification information shown in Section 3 to be sure which services require prior approval or precertification.**
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
  - The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment).
  - We provide benefits at 85% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our payment and the billed amount.
  - You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 24 for more information.
- **Under Basic Option,**
  - There is **no calendar year deductible**.
  - **You must use Preferred providers in order to receive benefits. See below and page 21 for the exceptions to this requirement.**
  - We provide benefits at Preferred benefit levels for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our payment and the billed amount.

Benefit Description	You Pay	
Note: **For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.**		
Surgical procedures	**Standard Option**	**Basic Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures and dislocations, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus Colonoscopy, with or without biopsy ***Note:*** Preventive care benefits apply to the professional charges for your first covered colonoscopy of the calendar year (see page 43). We provide benefits as described here for subsequent colonoscopy procedures performed by a professional provider in the same year. • Endoscopic procedures • Injections • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery* on page 69) • Treatment of burns • Male circumcision • Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic devices, and Section 5(c) – Other hospital services and supplies – for our coverage for the device. • Voluntary sterilization for men (vasectomy) ***Note:*** See page 50 for our coverage of voluntary sterilization procedures for women. • Assistant surgeons/surgical assistance if required because of the complexity of the surgical procedures • Gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures to treat morbid obesity – a condition in which an individual has a Body Mass Index (BMI) of 40 or more, or an individual with a BMI of 35 or more with one or more co-morbidities; eligible members must be age 18 or over ***Note:*** **Benefits for the surgical treatment of morbid obesity are subject to the requirements listed on page 67.** ***Note:*** For certain surgical procedures, your out-of-pocket costs for facility services are reduced if you use a facility designated as a Blue Distinction Center. See pages 87-88 for information.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 24 for more information.	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 144 for more information about "agents.") Participating/Non-participating: You pay all charges

Surgical procedures – continued on next page

Surgical procedures *(continued)*	You Pay	
	Standard Option	Basic Option
Note: **Prior approval is required for outpatient surgery for morbid obesity.** For more information about prior approval, please refer to page 22. • Benefits for the surgical treatment of morbid obesity, performed on an inpatient or outpatient basis, are subject to the pre-surgical requirements listed below. **The member must meet all requirements.** – Diagnosis of morbid obesity (as defined on page 66) for a period of 2 years prior to surgery – Participation in a medically supervised weight loss program, including nutritional counseling, for at least 3 months prior to the date of surgery. (***Note:*** Benefits are not available for commercial weight loss programs; see page 43 for our coverage of nutritional counseling services.) – Pre-operative nutritional assessment and nutritional counseling about pre- and post-operative nutrition, eating, and exercise – Evidence that attempts at weight loss in the 1 year period prior to surgery have been ineffective – Psychological clearance of the member's ability to understand and adhere to the pre- and post-operative program, based on a psychological assessment performed by a licensed professional mental health practitioner (see page 99 for our payment levels for mental health services) – Member has not smoked in the 6 months prior to surgery – Member has not been treated for substance abuse for 1 year prior to surgery and there is no evidence of substance abuse during the 1-year period prior to surgery • Benefits for subsequent surgery for morbid obesity, performed on an inpatient or outpatient basis, are subject to the following additional pre-surgical requirements: – All criteria listed above for the initial procedure must be met again – Previous surgery for morbid obesity was at least 2 years prior to repeat procedure – Weight loss from the initial procedure was less than 50% of the member's excess body weight at the time of the initial procedure – Member complied with previously prescribed post-operative nutrition and exercise program • Claims for the surgical treatment of morbid obesity must include documentation from the member's provider(s) that all pre-surgical requirements have been met.		

Surgical procedures – continued on next page

Surgical procedures *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Note: When multiple surgical procedures that add time or complexity to patient care are performed during the same operative session, the Local Plan determines our allowance for the combination of multiple, bilateral, or incidental surgical procedures. Generally, we will allow a reduced amount for procedures other than the primary procedure. ***Note:*** We do not pay extra for "incidental" procedures (those that do not add time or complexity to patient care). ***Note:*** When unusual circumstances require the removal of casts or sutures by a physician other than the one who applied them, the Local Plan may determine that a separate allowance is payable.		
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby physician* • *Routine surgical treatment of conditions of the foot [see Section 5(a)* – Foot care*]* • *Cosmetic surgery* • *LASIK, INTACS, radial keratotomy, and other refractive surgery* • *Surgeries related to sex transformation* • *Surgeries related to sexual dysfunction or sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction)*	*All charges*	*All charges*

Reconstructive surgery	You Pay	
	Standard Option	**Basic Option**
• Surgery to correct a functional defect • Surgery to correct a congenital anomaly – a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. ***Note:*** Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth. ***Note:*** **You must get prior approval for outpatient surgical correction of congenital anomalies.** Please refer to page 22 for more information. • Treatment to restore the mouth to a pre-cancer state • All stages of breast reconstruction surgery following a mastectomy, such as: – Surgery to produce a symmetrical appearance of the patient's breasts – Treatment of any physical complications, such as lymphedemas ***Note:*** Internal breast prostheses are paid as orthopedic and prosthetic devices [see Section 5(a)]. See Section 5(c) when billed by a facility. ***Note:*** If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. • Surgery for placement of penile prostheses to treat erectile dysfunction	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 24 for more information.	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 144 for more information about "agents.") Participating/Non-participating: You pay all charges
Not covered: • *Cosmetic surgery – any operative procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form – unless required for a congenital anomaly or to restore or correct a part of the body that has been altered as a result of accidental injury, disease, or surgery (does not include anomalies related to the teeth or structures supporting the teeth)* • *Surgeries related to sex transformation* • *Surgeries related to sexual dysfunction or sexual inadequacy (except surgical placement of penile prostheses to treat erectile dysfunction)*	*All charges*	*All charges*

Oral and maxillofacial surgery	You Pay	
	Standard Option	**Basic Option**
Oral surgical procedures, limited to: • Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is necessary • Surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth ***Note:*** **You must get prior approval for outpatient surgery needed to correct accidental injuries as described above.** Please refer to page 22 for more information. • Excision of exostoses of jaws and hard palate • Incision and drainage of abscesses and cellulitis • Incision and surgical treatment of accessory sinuses, salivary glands, or ducts • Reduction of dislocations and excision of temporomandibular joints • Removal of impacted teeth ***Note:*** Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** You may request prior approval and receive specific benefit information in advance for surgeries to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 24 for more information.	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. ***Note:*** You pay 30% of the Plan allowance for agents, drugs, and/or supplies administered or obtained in connection with your care. (See page 144 for more information about "agents.") Participating/Non-participating: You pay all charges
Not covered: • *Oral implants and transplants except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Surgical procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Surgical procedures involving dental implants or preparation of the mouth for the fitting or the continued use of dentures, except for those required to treat accidental injuries as specifically described above and in Section 5(g)* • *Orthodontic care before, during, or after surgery, except for orthodontia associated with surgery to correct accidental injuries as specifically described above and in Section 5(g)*	*All charges*	*All charges*

Organ/tissue transplants

Prior approval requirements:

You must obtain prior approval (see page 22) from the Local Plan, for both the procedure and the facility, for the transplant procedures listed below. Prior approval is not required for kidney transplants or for transplants of corneal tissue.

- Blood or marrow stem cell transplant procedures

  Note: See pages 74 and 75 for **additional requirements** that apply to blood or marrow stem cell transplants that are covered **only** as part of a **clinical trial**.
- Autologous pancreas islet cell transplant
- Heart transplant
- Implantation of an artificial heart as a bridge to transplant or destination therapy
- Heart-lung transplant
- Intestinal transplants (small intestine with or without other organs)
- Liver transplant
- Lung (single, double, or lobar) transplant
- Pancreas transplant
- Simultaneous liver-kidney transplant
- Simultaneous pancreas-kidney transplant

Note: Refer to pages 22-23 for information about precertification of inpatient care.

Covered organ transplants are listed on page 72. Benefits are subject to medical necessity and experimental/investigational review, and to the prior approval requirements shown above.

Organ transplants must be performed in a facility with a Medicare-Approved Transplant Program for the type of transplant anticipated. Transplants involving more than one organ must be performed in a facility that offers a Medicare-Approved Transplant Program for each organ transplanted. Medicare's approved programs are listed at: www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/downloads/ApprovedTransplantPrograms.pdf.

If Medicare does not offer an approved program for a certain type of organ transplant procedure, this requirement does not apply and you may use any covered facility that performs the procedure. If Medicare offers an approved program for an anticipated organ transplant, but your facility is not approved by Medicare for the procedure, please contact your Local Plan at the customer service number appearing on the back of your ID card.

Blood or marrow stem cell transplants are covered as shown on pages 72-75. Benefits are limited to the stages of the diagnoses listed.

Physicians consider many features to determine how diseases will respond to different types of treatments. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. For the diagnoses listed on pages 72-73, the medical necessity limitation is considered satisfied if the patient meets the staging description.

The blood or marrow stem cell transplants listed on pages 72-74 must be performed in a facility with a transplant program accredited by the Foundation for the Accreditation of Cellular Therapy (FACT), or in a facility designated as a Blue Distinction Center for Transplants or as a Cancer Research Facility**.** The **transplant procedures listed on page 75** must be performed at a FACT-accredited facility. See page 20 for more information about these types of facilities.

Not every facility provides transplant services for every type of transplant procedure or condition listed, or is designated or accredited for every covered transplant. Benefits are not provided for a covered transplant procedure unless the facility is specifically designated or accredited to perform that procedure. Before scheduling a transplant, call your Local Plan at the customer service number appearing on the back of your ID card for assistance in locating an eligible facility and requesting prior approval for transplant services.

Note: Coverage for the blood or marrow stem cell transplants described on pages 72-73 includes benefits for those transplants performed in an approved clinical trial to treat any of the conditions listed when prior approval is obtained. Refer to pages 74-75 for information about **blood or marrow stem cell transplants covered only in clinical trials** and the **additional requirements** that apply.

Note: See page 137 for our coverage of other costs associated with clinical trials.

Note: We provide enhanced benefits for covered transplant services performed at Blue Distinction Centers for Transplants (see page 77 for more information).

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
• Transplants of corneal tissue • Heart transplant • Heart-lung transplant • Kidney transplant • Liver transplant • Pancreas transplant • Simultaneous pancreas-kidney transplant • Simultaneous liver-kidney transplant • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Single, double, or lobar lung transplant • For members with end-stage cystic fibrosis, benefits for lung transplantation are limited to double lung transplants • Implantation of an artificial heart as a bridge to transplant or destination therapy ***Note:*** See page 71 for the prior approval and facility requirements that apply **to organ/tissue transplants**.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** You may request prior approval and receive specific benefit information in advance for kidney and cornea transplants to be performed by Non-participating physicians when the charge for the surgery will be **$5,000 or more**. See page 24 for more information.	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Allogeneic blood or marrow stem cell transplants limited to the stages of the following diagnoses: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) with poor response to therapy, short time to progression, transformed disease, or high risk disease • Chronic myelogenous leukemia • Hemoglobinopathy (i.e., Sickle cell anemia, Thalassemia major) • High-risk neuroblastoma • Hodgkin's lymphoma • Infantile malignant osteopetrosis • Inherited metabolic disorders (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy, Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants)		

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
• Marrow failure [i.e., severe or very severe aplastic anemia, Fanconi's Anemia, Paroxysmal nocturnal hemoglobinuria (PNH), pure red cell aplasia, congenital thrombocytopenia] • MDS/MPN [e.g., Chronic myelomonocytic leukemia (CMML)] • Myelodysplasia/Myelodysplastic syndromes (MDS) • Myeloproliferative neoplasms (MPN) (e.g., Polycythemia vera, Essential thrombocythemia, Primary myelofibrosis) • Non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) • Plasma Cell Disorders [e.g., Multiple Myeloma, Amyloidosis, Polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes (POEMS) syndrome] • Primary Immunodeficiencies (e.g., Severe combined immunodeficiency, Wiskott-Aldrich syndrome, hemophagocytic lymphohistiocytosis, X-linked lymphoproliferative syndrome, Kostmann's syndrome, Leukocyte adhesion deficiencies) ***Note:*** See page 71 for the prior approval and facility requirements that apply to **blood or marrow stem cell transplants**. ***Note:*** Refer to pages 74-75 for information about **blood or marrow stem cell transplants covered only in clinical trials**.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges
Autologous blood or marrow stem cell transplants limited to the stages of the following diagnoses: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Central Nervous System (CNS) Embryonal tumors [e.g., atypical teratoid/rhabdoid tumor, primitive neuroectodermal tumors (PNETs), medulloblastoma, pineoblastoma, ependymoblastoma] • Ewing's sarcoma • Germ cell tumors (e.g., testicular germ cell tumors) • High-risk neuroblastoma • Hodgkin's lymphoma • Non-Hodgkin's lymphoma (e.g., Waldenstrom's macroglobulinemia, B-cell lymphoma, Burkitt Lymphoma) • Plasma Cell Disorders [e.g., Multiple Myeloma, Amyloidosis, Polyneuropathy, organomegaly, endocrinopathy, monoclonal gammopathy, and skin changes (POEMS) syndrome] ***Note:*** See page 71 for the prior approval and facility requirements that apply to **blood or marrow stem cell transplants**. ***Note:*** Refer to pages 74-75 for information about **blood or marrow stem cell transplants covered only in clinical trials.**	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	You Pay	
	Standard Option	**Basic Option**
Blood or marrow stem cell transplants limited to the stages of the following diagnoses, **only** when performed as part of a clinical trial that meets the facility criteria described on page 71 and the **requirements** listed on page 75: • Allogeneic blood or marrow stem cell transplants for: – Breast cancer – Colon cancer – Glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme) – Epidermolysis bullosa – Ovarian cancer – Prostate cancer – Renal cell carcinoma – Retinoblastoma – Rhabdomyosarcoma – Sarcoma – Wilm's Tumor • Autologous blood or marrow stem cell transplants for: – Breast cancer – Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – Chronic myelogenous leukemia – Epithelial ovarian cancer – Glial tumors (e.g., anaplastic astrocytoma, choroid plexus tumors, ependymoma, glioblastoma multiforme) – Retinoblastoma – Rhabdomyosarcoma – Wilm's Tumor and other childhood kidney cancers ***Note:*** If a non-randomized clinical trial for a blood or marrow stem cell transplant listed above meeting the **requirements** shown on page 75 is not available, we will arrange for the transplant to be provided at an approved transplant facility, if available.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	You Pay	
	Standard Option	**Basic Option**
Blood or marrow stem cell transplants limited to the stages of the following diagnoses, **only** when performed at a FACT-accredited facility (see page 20) as part of a **clinical trial** that meets the **requirements** listed below: • Nonmyeloablative or reduced-intensity conditioning (RIC) allogeneic blood or marrow stem cell transplants or autologous blood or marrow stem cell transplants for: – Autoimmune disease (e.g., Multiple sclerosis, Scleroderma, Systemic lupus erythematosus, Chronic inflammatory demyelinating polyneuropathy) **Requirements** for **blood or marrow stem cell transplants** covered **only** under **clinical trials**: • You must contact us at the customer service number listed on the back of your ID card to obtain prior approval (see page 23); and • The patient must be properly and lawfully registered in the clinical trial, meeting all the eligibility requirements of the trial; and – For the transplant procedures listed above, the clinical trial must be reviewed and approved by the Institutional Review Board (IRB) of the FACT-accredited facility where the procedure is to be performed; and – For the transplant procedures listed on page 74, the clinical trial must be reviewed and approved by the IRB of the FACT-accredited facility, Blue Distinction Center for Transplants, or Cancer Research Facility where the procedure is to be performed. ***Note:*** Clinical trials are research studies in which physicians and other researchers work to find ways to improve care. Each study tries to answer scientific questions and to find better ways to prevent, diagnose, or treat patients. A clinical trial has possible benefits as well as risks. Each trial has a protocol which explains the purpose of the trial, how the trial will be performed, who may participate in the trial, and the beginning and end points of the trial. Information regarding clinical trials is available at www.cancer.gov/about-cancer/treatment/clinical-trials. Even though we may state benefits are available for a specific type of clinical trial, you may not be eligible for inclusion in these trials or there may not be any trials available in a FACT-accredited facility, Blue Distinction Center for Transplants, or Cancer Research Facility to treat your condition at the time you seek to be included in a clinical trial. If your physician has recommended you participate in a clinical trial, we encourage you to contact the Case Management Department at your Local Plan for assistance. ***Note:*** See page 137 for our coverage of other costs associated with clinical trials.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Related transplant services: • Extraction or reinfusion of blood or marrow stem cells as part of a covered allogeneic or autologous blood or marrow stem cell transplant • Harvesting, immediate preservation, and storage of stem cells when the autologous blood or marrow stem cell transplant has been scheduled or is anticipated to be scheduled within an appropriate time frame for patients diagnosed at the time of harvesting with one of the conditions listed on pages 73-75 ***Note:*** Benefits are available for charges related to fees for storage of harvested autologous blood or marrow stem cells related to a covered autologous stem cell transplant that has been scheduled or is anticipated to be scheduled within an appropriate time frame. No benefits are available for any charges related to fees for long term storage of stem cells. • Collection, processing, storage, and distribution of cord blood only when provided as part of a blood or marrow stem cell transplant scheduled or anticipated to be scheduled within an appropriate time frame for patients diagnosed with one of the conditions listed on pages 73-75 • Related medical and hospital expenses of the donor, when we cover the recipient • Related services or supplies provided to the recipient • Donor screening tests for up to three non-full sibling (such as unrelated) potential donors, for any full sibling potential donors, and for the actual donor used for transplant ***Note:*** See Section 5(a) for coverage for related services, such as chemotherapy and/or radiation therapy and drugs administered to stimulate or mobilize stem cells for covered transplant procedures.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: $150 copayment per performing surgeon, for surgical procedures performed in an office setting Preferred: $200 copayment per performing surgeon, for surgical procedures performed in all other settings ***Note:*** Your provider will document the place of service when filing your claim for the procedure(s). Please contact the provider if you have any questions about the place of service. ***Note:*** If you receive the services of a co-surgeon, you pay a separate copayment for those services, based on where the surgical procedure is performed. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	You Pay	
	Standard Option	Basic Option
Organ/Tissue Transplants at Blue Distinction Centers for Transplants® We participate in the Blue Distinction Centers for Transplants Program for the organ/tissue transplants listed below. Members who choose to use a Blue Distinction Center for Transplants for a covered transplant only pay the $350 per admission copayment under Standard Option, or the $175 per day copayment ($875 maximum) under Basic Option, for the transplant period. See page 151 for the definition of "transplant period." Members are not responsible for additional costs for included professional services. Regular benefits (subject to the regular cost-sharing levels for facility and professional services) are paid for pre- and post-transplant services performed in Blue Distinction Centers for Transplants before and after the transplant period and for services unrelated to a covered transplant. **All members (including those who have Medicare Part A or another group health insurance policy as their primary payor) must contact us at the customer service number listed on the back of their ID card before obtaining services.** You will be referred to the designated Plan transplant coordinator for information about Blue Distinction Centers for Transplants. • Heart (adult and pediatric) • Liver (adult and pediatric liver alone; adult only for simultaneous liver-kidney) • Pancreas; pancreas transplant alone; pancreas after kidney; simultaneous pancreas-kidney (adult only) • Single or double lung (adult only) • Blood or marrow stem cell transplants (adult and pediatric) listed on pages 72-75 • Related transplant services listed on page 76		
Travel benefits: Members who receive covered care at a Blue Distinction Center for Transplants for one of the transplants listed above can be reimbursed for incurred travel costs related to the transplant, subject to the criteria and limitations described here. We reimburse costs for transportation (air, rail, bus, and/or taxi) and lodging if you live 50 miles or more from the facility, up to a maximum of $5,000 per transplant for the member and one companion. If the transplant recipient is age 21 or younger, we pay up to $10,000 for eligible travel costs for the member and two caregivers. Reimbursement is subject to IRS regulations. ***Note:*** You must obtain prior approval for travel benefits (see page 23).		
Note: Benefits for cornea, kidney-only, intestinal, pediatric pancreas, pediatric lung, and heart-lung transplants are not available through Blue Distinction Centers for Transplants. See page 72 for benefit information for these transplants. ***Note:*** See Section 5(c) for our benefits for facility care. ***Note:*** See pages 71 and 72-76 for requirements related to blood or marrow stem cell transplant coverage.		
Not covered: • *Transplants for any diagnosis not listed as covered* • *Donor screening tests and donor search expenses, including associated travel expenses, except as defined on page 76* • *Implants of artificial organs, including those implanted as a bridge to transplant and/or as destination therapy, other than medically necessary implantation of an artificial heart as described on page 72* • *Allogeneic pancreas islet cell transplantation* • *Travel costs related to covered transplants performed at facilities other than Blue Distinction Centers for Transplants; travel costs incurred when prior approval has not been obtained; travel costs outside those allowed by IRS regulations, such as food-related expenses*	*All charges*	*All charges*

Anesthesia	You Pay	
	Standard Option	Basic Option
Anesthesia (including acupuncture) for covered medical or surgical services when requested by the attending physician and performed by: • A certified registered nurse anesthetist (CRNA), or • A physician other than the physician (or the assistant) performing the covered medical or surgical procedure Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Residential treatment center • Office Anesthesia services consist of administration by injection or inhalation of a drug or other anesthetic agent (including acupuncture) to obtain muscular relaxation, loss of sensation, or loss of consciousness. ***Note:*** See Section 5(c) for our payment levels for anesthesia services billed by a facility.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3 to be sure which services require precertification.
- YOU MUST GET PRECERTIFICATION FOR RESIDENTIAL TREATMENT CENTER STAYS. Please refer to the precertification information listed in Section 3.
- ***Note:*** **Observation services** are billed as outpatient facility care. Benefits for observation services are provided at the outpatient facility benefit levels described on page 84. See page 148 for more information about these types of services.
- **YOU MUST GET PRIOR APPROVAL for the following surgical services if they are to be performed on an outpatient basis: surgery for morbid obesity; surgical correction of congenital anomalies; and outpatient surgery needed to correct accidental injuries (see *Definitions*) to jaws, cheeks, lips, tongue, roof and floor of mouth. Please refer to page 22 for more information.**
- You should be aware that some PPO inpatient facilities may have non-PPO professional providers on staff.
- We base payment on whether a facility or a health care professional bills for the services or supplies. 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 what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a physician, a physical therapist, or an outpatient facility.
- The services listed in this Section are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service, for your inpatient or outpatient surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are listed in Sections 5(a) or 5(b).
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
  - The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment).
- **Under Basic Option,**
  - There is **no calendar year deductible.**
  - **You must use Preferred providers in order to receive benefits.** See page 21 for the exceptions to this requirement.
  - Your cost-share for care performed and billed by Preferred professional providers in the outpatient department of a Preferred hospital is waived for services other than surgical services, drugs, supplies, orthopedic and prosthetic devices, and durable medical equipment. You are responsible for the applicable cost-sharing amount(s) for the services performed and billed by the hospital.

Benefit Description	You Pay	
Note: **For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.**		
Inpatient hospital	**Standard Option**	**Basic Option**
Room and board, such as: • Semiprivate or intensive care accommodations • General nursing care • Meals and special diets ***Note:*** We cover a private room only when you must be isolated to prevent contagion, when your isolation is required by law, or when a Preferred or Member hospital only has private rooms. If a Preferred or Member hospital only has private rooms, we base our payment on the contractual status of the facility. If a Non-member hospital only has private rooms, we base our payment on the Plan allowance for your type of admission. Please see page 148 for more information. See pages 88 and 100 for inpatient residential treatment center.	Preferred: $350 per admission copayment for unlimited days (no deductible) Member: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment ***Note:*** If you are admitted to a Member or Non-member facility due to a **medical emergency or accidental injury**, you pay a $450 per admission copayment for unlimited days and we then provide benefits at 100% of the Plan allowance.	Preferred: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member: You pay all charges

Inpatient hospital – continued on next page

Inpatient hospital *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs • Diagnostic studies, radiology services, laboratory tests, and pathology services • Administration of blood or blood plasma • Dressings, splints, casts, and sterile tray services • Internal prosthetic devices • Other medical supplies and equipment, including oxygen • Anesthetics and anesthesia services • Take-home items • Pre-admission testing recognized as part of the hospital admissions process • Nutritional counseling • Acute inpatient rehabilitation ***Note:*** **Observation services** are billed as outpatient facility care. As a result, benefits for observation services are provided at the outpatient facility benefit levels described on page 84. See page 148 for more information about these types of services. ***Note:*** Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 26 for other circumstances, such as extended stays for you or your baby. • If you need to stay longer in the hospital than initially planned, we will cover an extended stay if it is medically necessary. However, you must precertify the extended stay. See Section 3 for information on requesting additional days. • We pay inpatient hospital benefits for an admission in connection with the treatment of children up to age 22 with severe dental caries. We cover hospitalization for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. We provide benefits for dental procedures as shown in Section 5(g). ***Note:*** See pages 48-49 for other covered maternity services. ***Note:*** See page 61 for coverage of blood and blood products. ***Note:*** For certain surgical procedures, your out-of-pocket costs for facility services are reduced if you use a facility designated as a Blue Distinction Center. See page 87 for information.	Preferred: $350 per admission copayment for unlimited days (no deductible) ***Note:*** For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use a Preferred facility. Member: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred: $175 per day copayment up to $875 per admission for unlimited days ***Note:*** For Preferred facility care related to maternity (including inpatient facility care, care at birthing facilities, and services you receive on an outpatient basis), your responsibility for the covered services you receive is limited to $175 per admission. Member/Non-member: You pay all charges

Inpatient hospital – continued on next page

Inpatient hospital *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Not covered: • *Admission to noncovered facilities, such as nursing homes, extended care facilities, schools, or residential treatment centers (except as described on page 100)* • *Personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services* • *Private duty nursing* *Hospital room and board expenses when, in our judgment, a hospital admission or portion of an admission is:* • *Custodial or long term care (see* Definitions*)* • *Convalescent care or a rest cure* • *Domiciliary care provided because care in the home is not available or is unsuitable* • *Not medically necessary, such as when services did not require the acute hospital inpatient (overnight) setting but could have been provided safely and adequately in a physician's office, the outpatient department of a hospital, or some other setting, without adversely affecting your condition or the quality of medical care you receive. Some examples are:* – *Admissions for, or consisting primarily of, observation and/or evaluation that could have been provided safely and adequately in some other setting (such as a physician's office)* – *Admissions primarily for diagnostic studies, radiology services, laboratory tests, or pathology services that could have been provided safely and adequately in some other setting (such as the outpatient department of a hospital or a physician's office)* **Note:** *If we determine that a hospital admission is one of the types listed above, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting. Benefits are limited to care provided by covered facility providers (see pages 19-20).*	*All charges*	*All charges*

Outpatient hospital or ambulatory surgical center	You Pay	
	Standard Option	Basic Option
Outpatient **surgical and treatment services** performed and billed by a facility, such as: • Operating, recovery, and other treatment rooms • Anesthetics and anesthesia services • Pre-surgical testing performed within one business day of the covered surgical services • Chemotherapy and radiation therapy • Colonoscopy, with or without biopsy ***Note:*** Preventive care benefits apply to the facility charges for your first covered colonoscopy of the calendar year (see page 43). We provide diagnostic benefits for services related to subsequent colonoscopy procedures in the same year. • Intravenous (IV)/infusion therapy • Renal dialysis • Visits to the outpatient department of a hospital for non-emergency treatment services • Diabetic education • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced, and other biologicals • Dressings, splints, casts, and sterile tray services • Facility supplies for hemophilia home care • Other medical supplies, including oxygen • Surgical implants ***Note:*** See pages 93-96 for our payment levels for care related to a medical emergency or accidental injury. ***Note:*** See pages 50-51 for our coverage of family planning services. ***Note:*** For our coverage of hospital-based clinic visits, please refer to the professional benefits described on page 39. ***Note:*** For certain surgical procedures, your out-of-pocket costs for facility services are reduced if you use a facility designated as a Blue Distinction Center. See page 87 for information. ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility. See pages 48-50 for other included maternity services. ***Note:*** See page 86 for outpatient drugs, medical devices, and durable medical equipment billed for by a facility.	Preferred facilities: 15% of the Plan allowance (deductible applies) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred: $100 copayment per day per facility (except as noted below) ***Note:*** You may be responsible for paying a $150 copayment per day per facility if other diagnostic services are billed in addition to the services listed here. ***Note:*** You pay 30% of the Plan allowance for surgical implants, agents, or drugs administered or obtained in connection with your care. (See page 144 for more information about "agents.") Member/Non-member: You pay all charges

Outpatient hospital or ambulatory surgical center – continued on next page

Outpatient hospital or ambulatory surgical center *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Note: We cover outpatient hospital services and supplies related to the treatment of children up to age 22 with severe dental caries. We cover outpatient care related to other types of dental procedures only when a non-dental physical impairment exists that makes the hospital setting necessary to safeguard the health of the patient. See Section 5(g), *Dental benefits*, for additional benefit information.		
Outpatient **observation services** performed and billed by a hospital or freestanding ambulatory facility ***Note:*** All outpatient services billed by the facility during the time you are receiving observation services are included in the cost-share amounts shown here. Please refer to Section 5(a) for services billed by professional providers during an observation stay and pages 79-81 for information about benefits for inpatient admissions. ***Note:*** For outpatient observation services related to maternity, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.	Preferred: $350 copayment for the duration of services (no deductible) Member: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible) Non-member: $450 copayment for the duration of services, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred: $175 per day copayment up to $875 Member/Non-member: You pay all charges
Outpatient **diagnostic testing and treatment services** performed and billed by a facility, limited to: • Angiographies • Bone density tests • CT scans/MRIs/PET scans • Genetic testing ***Note:*** We cover specialized diagnostic genetic testing billed for by a facility, such as the outpatient department of a hospital, as shown here. See page 41 for coverage criteria and limitations. • Nuclear medicine • Sleep studies	Preferred facilities: 15% of the Plan allowance (deductible applies) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred: $150 copayment per day per facility Member: $150 copayment per day per facility Non-member: $150 copayment per day per facility, plus any difference between our allowance and the billed amount ***Note:*** You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 144 for more information about "agents.")

Outpatient hospital or ambulatory surgical center – continued on next page

Outpatient hospital or ambulatory surgical center *(continued)*	You Pay	
	Standard Option	**Basic Option**
Outpatient **diagnostic testing services** performed and billed by a facility, including but not limited to: • Cardiovascular monitoring • EEGs • Ultrasounds • Neurological testing • X-rays (including set-up of portable X-ray equipment) ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.	Preferred facilities: 15% of the Plan allowance (deductible applies) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred: $40 copayment per day per facility Member: $40 copayment per day per facility Non-member: $40 copayment per day per facility, plus any difference between our allowance and the billed amount ***Note:*** You may be responsible for paying a higher copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here. ***Note:*** You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 144 for more information about "agents.")
Outpatient **treatment services** performed and billed by a facility, limited to: • Cardiac rehabilitation • Cognitive rehabilitation • Pulmonary rehabilitation • Physical, occupational, and speech therapy	Preferred facilities: 15% of the Plan allowance (deductible applies) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount. ***Note:*** We provide benefits for physical, occupational, and speech therapy as described on page 55, regardless of the type of covered provider billing for the services.	Preferred: $30 copayment per day per facility ***Note:*** You may be responsible for paying a higher copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here. ***Note:*** You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 144 for more information about "agents.") ***Note:*** Benefits are limited to a total of 50 visits per person, per calendar year for outpatient physical, occupational, or speech therapy, or a combination of all three, regardless of the type of covered provider billing for the services. Member/Non-member: You pay all charges

Outpatient hospital or ambulatory surgical center – continued on next page

Outpatient hospital or ambulatory surgical center *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Outpatient **diagnostic and treatment services** performed and billed by a facility, limited to: • Laboratory tests and pathology services • EKGs ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.	Preferred facilities: 15% of the Plan allowance (deductible applies) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred: Nothing Member: Nothing Non-member: You pay any difference between our allowance and the billed amount ***Note:*** You may be responsible for paying a copayment per day per facility if other diagnostic and/or treatment services are billed in addition to the services listed here. ***Note:*** You pay 30% of the Plan allowance for agents or drugs administered or obtained in connection with your care. (See page 144 for more information about "agents.")
Outpatient **adult preventive care** performed and billed by a facility, limited to: • Visits/exams for preventive care, screening procedures, and routine immunizations described on pages 42-46 • Cancer screenings listed on page 43 and ultrasound screening for abdominal aortic aneurysm ***Note:*** See pages 44-45 for our coverage requirements for preventive BRCA testing. ***Note:*** See page 47 for our payment levels for covered preventive care services for children billed for by facilities and performed on an outpatient basis.	See pages 42-46 for our payment levels for covered preventive care services for adults	Preferred: Nothing Member/Non-member: Nothing for cancer screenings and ultrasound screening for abdominal aortic aneurysm ***Note:*** Benefits are not available for routine adult physical examinations, associated laboratory tests, colonoscopies, or routine immunizations performed at Member or Non-member facilities.
Outpatient **drugs, medical devices, and durable medical equipment** billed for by a facility, such as: • Prescribed drugs • Orthopedic and prosthetic devices • Durable medical equipment ***Note:*** For outpatient facility care related to maternity, including outpatient care at birthing facilities, we waive your cost-share amount and pay for covered services in full when you use a Preferred facility.	Preferred facilities: 15% of the Plan allowance (deductible applies) Member facilities: 35% of the Plan allowance (deductible applies) Non-member facilities: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred: 30% of the Plan allowance ***Note:*** You may also be responsible for paying a copayment per day per facility for outpatient services. See above and pages 83-85 for specific coverage information. Member/Non-member: You pay all charges

Blue Distinction Centers®	You Pay	
	Standard Option	Basic Option
We provide enhanced benefits for covered inpatient facility services related to the surgical procedures listed below, when the surgery is performed at a facility designated as a Blue Distinction Center for Bariatric Surgery, Knee and Hip Replacement, or Spine Surgery. • Bariatric surgery, subject to the requirements listed on pages 66-67 • Total hip replacement or revision • Total knee replacement or revision • Spine surgery, limited to: – Cervical discectomy – Thoracic discectomy – Laminectomy – Laminoplasty – Spinal fusion ***Note:*** You must precertify your hospital stay and verify your facility's designation as a Blue Distinction Center for the type of surgery being scheduled. Contact us prior to your admission at the customer service number listed on the back of your ID card for assistance. ***Note:*** Members are responsible for regular cost-sharing amounts for the surgery and related professional services as described in Section 5(b). ***Note:*** These benefit levels do not apply to inpatient facility care related to other services or procedures, or to outpatient facility care, even if the services are performed at a Blue Distinction Center. See pages 80-81 for regular inpatient hospital benefits and pages 83-86 for outpatient facility benefit levels. ***Note:*** See page 20 for more information about Blue Distinction Centers.	Blue Distinction Center: $150 per admission copayment for unlimited days (no deductible)	Blue Distinction Center: $100 per day copayment up to $500 per admission for unlimited days
Outpatient facility services related to laparoscopic gastric banding surgery or gastric stapling surgical procedures, when the surgery is performed at a facility designated as a Blue Distinction Center for Bariatric Surgery ***Note:*** You must meet the pre-surgical requirements listed on pages 66-67. In addition, you must obtain prior approval and verify the facility's designation as a Blue Distinction Center for the type of surgery being scheduled. Contact us prior to the procedure at the customer service number listed on the back of your ID card for assistance. ***Note:*** Members are responsible for regular cost-sharing amounts for the surgery and related professional services as described in Section 5(b).	Blue Distinction Center: $100 per day per facility (no deductible)	Blue Distinction Center: $25 per day per facility

Blue Distinction Centers® – continued on next page

Blue Distinction Centers® *(continued)*	You Pay	
	Standard Option	**Basic Option**
Note: These benefits do not apply to other types of outpatient surgical services, even when performed at a Blue Distinction Center. See pages 83-86 for the benefits we provide. ***Note:*** See page 20 for more information about Blue Distinction Centers.		
Residential Treatment Center		
Precertification prior to admission is required. A preliminary treatment plan and discharge plan must be developed and agreed to by the member, provider (residential treatment center (RTC)), and case manager in the Local Plan where the RTC is located prior to admission. We cover inpatient care provided and billed by an RTC for members enrolled and participating in case management through the Local Plan, when the care is medically necessary for treatment of a medical, mental health, and/or substance abuse condition: • Room and board, such as semiprivate room, nursing care, meals, special diets, ancillary charges, and covered therapy services when billed by the facility (see page 39 for services billed by professional providers). ***Note:*** RTC benefits are not available for facilities licensed as a skilled nursing facility, group home, halfway house, or similar type facility. ***Note:*** Benefits are not available for non-covered services, including: respite care; outdoor residential programs; services provided outside of the provider's scope of practice; recreational therapy; educational therapy; educational classes; bio-feedback; Outward Bound programs; equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services; custodial or long term care (see *Definitions*); and domiciliary care provided because care in the home is not available or is unsuitable.	Preferred: $350 per admission copayment for unlimited days (no deductible) Member: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment ***Note:*** Non-member RTCs must, prior to admission, agree to abide by the terms established by the Local Plan for the care of the particular member and for the submission and processing of related claims.	Preferred: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member: You pay all charges

Extended care benefits/Skilled nursing care facility benefits	You Pay	
	Standard Option	**Basic Option**
Limited to the following benefits for Medicare Part A copayments: When Medicare Part A is the primary payor (meaning that it pays first) and has made payment, **Standard Option** provides limited secondary benefits. We pay the applicable Medicare Part A copayments incurred **in full** during the first through the 30th day of confinement for each benefit period (as defined by Medicare) in a qualified skilled nursing facility. A qualified skilled nursing facility is a facility that specializes in skilled nursing care performed by or under the supervision of licensed nurses, skilled rehabilitation services, and other related care, and meets Medicare's special qualifying criteria, but is not an institution that primarily cares for and treats mental diseases. If Medicare pays the first 20 days in full, Plan benefits will begin on the 21st day (when Medicare Part A copayments begin) and will end on the 30th day. ***Note:*** See page 55 for benefits provided for outpatient physical, occupational, speech, and cognitive rehabilitation therapy when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs. ***Note:*** **If you do not have Medicare Part A, we do not provide benefits for skilled nursing facility care.**	Preferred: Nothing (no deductible) Participating/Member: Nothing (no deductible) Non-participating/Non-member: Nothing (no deductible) ***Note:*** You pay all charges not paid by Medicare after the 30th day.	*All charges*
Hospice care		
Hospice care is an integrated set of services and supplies designed to provide palliative and supportive care to members with a projected life expectancy of six months or less due to a terminal medical condition, as certified by the member's primary care provider or specialist.	See below and page 91	See below and page 91
Pre-Hospice Enrollment Benefits **Prior approval is not required.** Before home hospice care begins, members may be evaluated by a physician to determine if home hospice care is appropriate. We provide benefits for pre-enrollment visits when provided by a physician who is employed by the home hospice agency and when billed by the agency employing the physician. The pre-enrollment visit includes services such as: • Evaluating the member's need for pain and/or symptom management; and • Counseling regarding hospice and other care options	Nothing (no deductible)	Nothing

Hospice care – continued on next page

Hospice care *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Prior approval from the Local Plan is required for all hospice services. Our prior approval decision will be based on the medical necessity of the hospice treatment plan and the clinical information provided to us by the primary care provider (or specialist) and the hospice provider. We may also request information from other providers who have treated the member. All hospice services must be billed by the approved hospice agency. **You are responsible for making sure the hospice care provider has received prior approval from the Local Plan** (see pages 22-23 for instructions). Please check with your Local Plan, and/or visit www.fepblue.org/provider to use our National Doctor & Hospital Finder, for listings of Preferred hospice providers. ***Note:*** If Medicare Part A is the primary payor for the member's hospice care, prior approval is not required. However, our benefits will be limited to those services listed above and on page 91. **Members with a terminal medical condition (or those acting on behalf of the member) are encouraged to contact the Case Management Department at their Local Plan for information about hospice services and Preferred hospice providers.**		
Covered services We provide benefits for the hospice services listed below when the services have been included in an approved hospice treatment plan and are provided by the home hospice program in which the member is enrolled: • Nursing care • Periodic physician visits • Dietary counseling • Durable medical equipment rental • Medical social services • Medical supplies • Oxygen therapy • Physical therapy, occupational therapy, and speech therapy related to the terminal medical condition • Prescription drugs • Services of home health aides (certified or licensed, if the state requires it, and provided by the home hospice agency)	See below	See below

Hospice care – continued on next page

Hospice care *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Traditional Home Hospice Care Periodic visits to the member's home for the management of the terminal medical condition and to provide limited patient care in the home. See page 90 for prior approval requirements.	Nothing (no deductible)	Nothing
Continuous Home Hospice Care Services provided in the home to members enrolled in home hospice during a period of crisis, such as frequent medication adjustments to control symptoms or to manage a significant change in the member's condition, requiring a minimum of 8 hours of care during each 24-hour period by a registered nurse (R.N.) or licensed practical nurse (L.P.N.). ***Note:*** Members must receive prior approval from the Local Plan for each episode of continuous home hospice care (see page 90). An episode consists of up to seven consecutive days of continuous care. Each episode must be separated by at least 21 days of traditional home hospice care. The member must be enrolled in a home hospice program and the continuous home hospice care services must be provided by the home hospice program in which the member is enrolled.	Preferred: $350 per episode copayment (no deductible) Member: $450 per episode copayment (no deductible) Non-member: $450 per episode copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred: $150 per day copayment up to $750 maximum per episode Member/Non-member: You pay all charges
Inpatient Hospice Care Benefits are available for inpatient hospice care when provided by a facility that is licensed as an inpatient hospice facility and when: • Inpatient services are necessary to control pain and/or manage the member's symptoms; • Death is imminent; or • Inpatient services are necessary to provide an interval of relief (respite) to the caregiver ***Note:*** Benefits are provided for up to thirty consecutive days in a facility licensed as an inpatient hospice facility. Each inpatient stay must be separated by at least 21 days of traditional home hospice care. The member does not have to be enrolled in a home hospice care program to be eligible for the first inpatient stay. However, the member must be enrolled in a home hospice care program in order to receive benefits for subsequent inpatient stays.	Preferred: Nothing (no deductible) Member: $450 per admission copayment, plus 35% of the Plan allowance (no deductible) Non-member: $450 per admission copayment, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment	Preferred: Nothing Member/Non-member: You pay all charges
Not covered: • *Homemaker services* • *Home hospice care (e.g., care given by a home health aide) that is provided and billed for by other than the approved home hospice agency when the same type of care is already being provided by the home hospice agency*	All charges	All charges

Ambulance	You Pay	
	Standard Option	Basic Option
Professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically necessary, and: • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required.	$100 copayment per day for ground ambulance transport services (no deductible) $150 copayment per day for air or sea ambulance transport services	$100 copayment per day for ground ambulance transport services $150 copayment per day for air or sea ambulance transport services
Professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically necessary, and when related to accidental injury ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required.	Nothing (no deductible) ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.	$100 copayment per day for ground ambulance transport services $150 copayment per day for air or sea ambulance transport services
Medically necessary emergency ground, air and sea ambulance transport services to the nearest hospital equipped to adequately treat your condition if you travel outside the United States, Puerto Rico and the U.S. Virgin Islands ***Note:*** If you are traveling overseas and need assistance with emergency evacuation services to the nearest facility equipped to adequately treat your condition, please contact Worldwide Assistance Center (provided by AXA Assistance) by calling the center collect at 1-804-673-1678. See page 123 for more information.	$100 copayment per day for ground ambulance transport services (no deductible) $150 copayment per day for air or sea ambulance transport services	$100 copayment per day for ground ambulance transport services (no deductible) $150 copayment per day for air or sea ambulance transport services
Not covered: • *Wheelchair van services and gurney van services* • *Ambulance and any other modes of transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests not associated with covered inpatient hospital care* • *Ambulance transport that is requested, beyond the nearest facility adequately equipped to treat the member's condition, by patient or physician for continuity of care or other reason* • *Commercial air flights* • *Repatriation from an international location back to the United States. See definition of repatriation in Section 10. Members traveling overseas should consider purchasing a travel insurance policy that covers repatriation to your home country.* • *Costs associated with overseas air or sea transportation to other than the closest hospital equipped to adequately treat your condition.*	*All charges*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- You should be aware that some Preferred (PPO) hospitals may have Non-preferred (non-PPO) professional providers on staff.
- We provide benefits at Preferred benefit levels for emergency room services performed by both PPO and non-PPO providers when their services are related to an accidental injury or medical emergency. The Plan allowance for these services is determined by the contracting status of the provider. If services are performed by non-PPO professional providers in a PPO facility, you will be responsible for your cost-share for those services, plus any difference between our allowance and the billed amount.
- PPO benefits apply only when you use a PPO provider (except as described above). When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
  - The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment).
- **Under Basic Option,**
  - There is **no calendar year deductible**.
  - **You must use Preferred providers in order to receive benefits, except in cases of medical emergency or accidental injury. Refer to the guidelines appearing below for additional information.**

What is an accidental injury?

An accidental injury is an injury caused by an external force or element such as a blow or fall and which requires immediate medical attention, including animal bites and poisonings. [See Section 5(g) for dental care for accidental injury.]

What is a medical emergency?

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

Basic Option benefits for emergency care

Under Basic Option, you are encouraged to seek care from Preferred providers in cases of accidental injury or medical emergency. However, if you need care immediately and cannot access a Preferred provider, we will provide benefits for the **initial** treatment provided in the emergency room of any hospital – even if the hospital is not a Preferred facility. We will also provide benefits if you are admitted directly to the hospital from the emergency room until your condition has been stabilized. In addition, we will provide benefits for emergency ambulance transportation provided by Preferred or Non-preferred ambulance providers if the transport is due to a medical emergency or accidental injury.

We provide emergency benefits when you have acute symptoms of sufficient severity – including severe pain – such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child.

Benefit Description	You Pay	
Note: **For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.**		
Accidental injury	**Standard Option**	**Basic Option**
• **Professional provider services** in the emergency room, hospital outpatient department, or provider's office, including professional care, diagnostic studies, radiology services, laboratory tests, and pathology services, when billed by a professional provider	Preferred: Nothing (no deductible) Participating: Nothing (no deductible) Non-participating: Any difference between our allowance and the billed amount (no deductible)	Preferred: Nothing Participating: Nothing Non-participating: You pay any difference between our allowance and the billed amount ***Note:*** These benefit levels apply only to professional provider services performed in the emergency room. Regular benefit levels apply to covered services provided in all other settings. See Sections 5(a) and 5(b) for those benefits.
• Outpatient **hospital services** and supplies, including professional provider services, diagnostic studies, radiology services, laboratory tests, and pathology services, when billed by the hospital	Preferred: Nothing (no deductible) Member: Nothing (no deductible) Non-member: Any difference between our allowance and the billed amount (no deductible)	Preferred emergency room: $125 copayment per visit Member emergency room: $125 copayment per visit Non-member emergency room: $125 copayment per visit, plus any difference between our allowance and the billed amount ***Note:*** If you are admitted directly to the hospital from the emergency room, you do not have to pay the $125 emergency room copayment. However, the $175 per day copayment for Preferred inpatient care still applies. ***Note:*** Regular benefit levels apply to covered outpatient hospital services provided in settings other than an emergency room. See Section 5(c) for those benefits.
• Urgent care center services	Preferred urgent care center: Nothing (no deductible) Participating urgent care center: Nothing (no deductible) Non-participating urgent care center: Any difference between our allowance and the billed amount (no deductible)	Preferred urgent care center: $35 copayment per visit Participating/Non-participating urgent care center: You pay all charges

Accidental injury – continued on next page

Accidental injury *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Note: If you are treated by a non-PPO professional provider in a PPO facility, you will be responsible for your cost-share for the services, plus any difference between our allowance and the billed amount. ***Note:*** We pay inpatient benefits if you are admitted. See Sections 5(a), 5(b), and 5(c) for those benefits. ***Note:*** See Section 5(g) for dental benefits for accidental injuries.	***Note:*** The benefits described above apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, regular benefits apply. See Sections 5(a), 5(b), and 5(c) for the benefits we provide. ***Note:*** For drugs, services, supplies, and/or durable medical equipment billed by a provider other than a hospital, urgent care center, or physician, see Sections 5(a) and 5(f) for the benefit levels that apply.	***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.
Not covered: • *Oral surgery except as shown in Section 5(b)* • *Injury to the teeth while eating* • *Emergency room professional charges for shift differentials*	*All charges*	*All charges*
Medical emergency		
• **Professional provider services in the emergency room,** including professional care, diagnostic studies, radiology services, laboratory tests, and pathology services, when billed by a professional provider	Preferred: 15% of the Plan allowance (deductible applies) Participating: 15% of the Plan allowance (deductible applies) Non-participating: 15% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: Nothing Participating: Nothing Non-participating: You pay any difference between our allowance and the billed amount
• Outpatient **hospital emergency room services** and supplies, including professional provider services, diagnostic studies, radiology services, laboratory tests, and pathology services, when billed by the hospital ***Note:*** We pay inpatient benefits if you are admitted as a result of a medical emergency. See Section 5(c). ***Note:*** Regular benefit levels apply to covered services provided in settings other than the emergency room. See Section 5(c) for those benefits.	Preferred: 15% of the Plan allowance (deductible applies) Member: 15% of the Plan allowance (deductible applies) Non-member: 15% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: $125 copayment per visit Member: $125 copayment per visit Non-member: $125 copayment per visit, plus any difference between our allowance and the billed amount ***Note:*** If you are admitted directly to the hospital from the emergency room, you do not have to pay the $125 emergency room copayment. However, the $175 per day copayment for Preferred inpatient care still applies. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.

Medical emergency – continued on next page

Medical emergency *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
• Urgent care center services	Preferred urgent care center: $30 copayment per visit (no deductible) Participating urgent care center: 35% of the Plan allowance (deductible applies) Non-participating urgent care center: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred urgent care center: $35 copayment per visit Participating/Non-participating urgent care center: You pay all charges
Note: If you are treated by a non-PPO professional provider in a PPO facility, you will be responsible for your cost-share for the services, plus any difference between our allowance and the billed amount. ***Note:*** We pay inpatient benefits if you are admitted. See Sections 5(a), 5(b), and 5(c) for those benefits.	***Note:*** These benefit levels **do not** apply if you receive care in connection with, and within 72 hours after, an accidental injury. See pages 94-95 for the benefits we provide.	***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.
Not covered: Emergency room professional charges for shift differentials	*All charges*	*All charges*

Ambulance	You Pay	
	Standard Option	Basic Option
Professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically necessary, and: • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required.	$100 copayment per day for ground ambulance transport services (no deductible) $150 copayment per day for air or sea ambulance transport services	$100 copayment per day for ground ambulance transport services $150 copayment per day for air or sea ambulance transport services
Professional ambulance **transport services** to or from the nearest hospital equipped to adequately treat your condition, when medically necessary, and when related to accidental injury ***Note:*** We also cover medically necessary emergency care provided at the scene when transport services are not required.	Nothing (no deductible) ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.	$100 copayment per day for ground ambulance transport services $150 copayment per day for air or sea ambulance transport services
Medically necessary emergency ground, air and sea ambulance transport services to the nearest hospital equipped to adequately treat your condition if you travel outside the United States, Puerto Rico and the U.S. Virgin Islands ***Note:*** If you are traveling overseas and need assistance with emergency evacuation services to the nearest facility equipped to adequately treat your condition, please contact Worldwide Assistance Center (provided by AXA Assistance) by calling the center collect at 1-804-673-1678. See page 123 for more information.	$100 copayment per day for ground ambulance transport services (no deductible) $150 copayment per day for air or sea ambulance transport services	$100 copayment per day for ground ambulance transport services (no deductible) $150 copayment per day for air or sea ambulance transport services
Not covered: • *Wheelchair van services and gurney van services* • *Ambulance and any other modes of transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests not associated with covered inpatient hospital care* • *Ambulance transport that is requested, beyond the nearest facility adequately equipped to treat the member's condition, by patient or physician for continuity of care or other reason* • *Commercial air flights* • *Repatriation from an international location back to the United States. See definition of repatriation in Section 10. Members traveling overseas should consider purchasing a travel insurance policy that covers repatriation to your home country.* • *Costs associated with overseas air or sea transportation to other than the closest hospital equipped to adequately treat your condition.*	*All charges*	*All charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you have a chronic and/or complex condition, you may be eligible to receive the services of a professional case manager to assist in assessing, planning, and facilitating individualized treatment options and care. For more information about our Case Management process, please refer to pages 122 and 144. Contact us at the telephone number listed on the back of your Service Benefit Plan ID card if you have any questions or would like to discuss your health care needs.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3.
- YOU MUST GET PRECERTIFICATION FOR RESIDENTIAL TREATMENT CENTER STAYS. Please refer to the precertification information listed in Section 3.
- PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Standard Option,**
- The calendar year deductible is $350 per person ($700 per Self Plus One or Self and Family enrollment).
- You may choose to receive care from In-Network (Preferred) or Out-of-Network (Non-preferred) providers. Cost-sharing and limitations for In-Network (Preferred) and Out-of-Network (Non-preferred) mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.
- **Under Basic Option,**
- **You must use Preferred providers in order to receive benefits. See page 21 for the exceptions to this requirement.**
- There is **no calendar year deductible**.

Benefit Description	You Pay	
Note: **For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.**		
Professional services	**Standard Option**	**Basic Option**
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Services provided by licensed professional mental health and substance abuse practitioners when acting within the scope of their license • Individual psychotherapy • Group psychotherapy • Pharmacologic (medication) management • Psychological testing • Office visits • Clinic visits • Home visits ***Note:*** To locate a Preferred provider, visit www.fepblue.org/provider to use our National Doctor & Hospital Finder, or contact your Local Plan at the mental health and substance abuse phone number on the back of your ID card. ***Note:*** See pages 64 and 112 for our coverage of smoking and tobacco cessation treatment. ***Note:*** See page 48 for our coverage of mental health visits to treat postpartum depression and depression during pregnancy.	Preferred: $25 copayment for the visit (no deductible) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus the difference between our allowance and the billed amount	Preferred: $30 copayment per visit Participating/Non-participating: You pay all charges
• Inpatient professional services	Preferred: Nothing (no deductible) Participating: 35% of the Plan allowance (no deductible) Non-participating: 35% of the Plan allowance (no deductible), plus the difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges
• Professional charges for facility-based intensive outpatient treatment • Professional charges for outpatient diagnostic tests	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus the difference between our allowance and the billed amount	Preferred: Nothing Participating/Non-participating: You pay all charges

Inpatient hospital or other covered facility	You Pay	
	Standard Option	**Basic Option**
Inpatient services provided and billed by a hospital or other covered facility (See below for residential treatment center care.) • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Diagnostic tests ***Note:*** Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a hospital/treatment facility for rehabilitative treatment of alcoholism or substance abuse. ***Note:*** You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	Preferred: $350 per admission copayment for unlimited days (no deductible) Member: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member: 35% of the Plan allowance for unlimited days (no deductible), and any remaining balance after our payment	Preferred: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member: You pay all charges
Residential Treatment Center		
Precertification prior to admission is required. A preliminary treatment plan and discharge plan must be developed and agreed to by the member, provider (residential treatment center (RTC)), and case manager in the Local Plan where the RTC is located prior to admission. We cover inpatient care provided and billed by an RTC for members enrolled and participating in case management through the Local Plan, when the care is medically necessary for treatment of a medical, mental health, and/or substance abuse condition: • *Room and board, such as semiprivate room, nursing care, meals, special diets, ancillary charges, and covered therapy services when billed by the facility (see page 99 for services billed by professional providers)* ***Note:*** RTC benefits are not available for facilities licenses as a skilled nursing facility, group home, halfway house, or similar type facility. ***Note:*** Benefits are not available for non-covered services, including: respite care; outdoor residential programs; services provided outside of the provider's scope of practice; recreational therapy; educational therapy; educational classes; bio-feedback; Outward Bound programs; equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services; custodial or long term care (see *Definitions*); and domiciliary care provided because care in the home is not available or is unsuitable.	Preferred: $350 per admission copayment for unlimited days (no deductible) Member: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible) Non-member: $450 per admission copayment for unlimited days, plus 35% of the Plan allowance (no deductible), and any remaining balance after our payment ***Note:*** Non-member facilities must, prior to admission, agree to abide by the terms established by the Local Plan for the care of the particular member and for the submission and processing of related claims.	Preferred: $175 per day copayment up to $875 per admission for unlimited days Member/Non-member: You pay all charges

Outpatient hospital or other covered facility	You Pay	
	Standard Option	**Basic Option**
Outpatient services provided and billed by a covered facility • Individual psychotherapy • Group psychotherapy • Pharmacologic (medication) management • Partial hospitalization • Intensive outpatient treatment	Preferred: 15% of the Plan allowance (deductible applies) Member: 35% of the Plan allowance (deductible applies) Non-member: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred: $30 copayment per day per facility Member/Non-member: You pay all charges
Outpatient services provided and billed by a covered facility • Diagnostic tests • Psychological testing	Preferred: 15% of the Plan allowance (deductible applies) Member: 35% of the Plan allowance (deductible applies) Non-member: 35% of the Plan allowance (deductible applies). You may also be responsible for any difference between our allowance and the billed amount.	Preferred: Nothing Member/Non-member: Nothing
Not covered (Inpatient or Outpatient)		
• *Marital, family, educational, or other counseling or training services* • *Services performed by a noncovered provider* • *Testing for and treatment of learning disabilities and intellectual disability* • *Applied behavior analysis (ABA) or ABA therapy* • *Inpatient services performed or billed by residential treatment centers, except as described on pages 88 and 100* • *Services performed or billed by schools, halfway houses, or members of their staffs* ***Note:*** *We cover professional services as described on page 99 when they are provided and billed by a covered professional provider acting within the scope of his or her license.* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present* • *Services performed or billed by residential therapeutic camps (e.g., wilderness camps, Outward Bound, etc.)* • *Light boxes* • *Custodial or long term care (see* Definitions*)*	*All charges*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescription drugs and supplies, as described in the chart beginning on page 106.
- If there is no generic drug available, you must still pay the brand-name cost-sharing amount when you receive a brand-name drug.
- For generic and brand-name drug purchases, if the cost of your prescription is less than your cost-sharing amount, you pay only the cost of your prescription.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRIOR APPROVAL FOR CERTAIN DRUGS AND SUPPLIES, and prior approval must be renewed periodically.** Prior approval is part of our Patient Safety and Quality Monitoring (PSQM) program. Please refer to page 105 for more information about the PSQM program and to Section 3 for more information about prior approval.
- During the course of the year, we may move a brand-name drug from Tier 2 (preferred brand-name) to Tier 3 (non-preferred brand-name) if a generic equivalent becomes available or if new safety concerns arise. We may also move a specialty drug from Tier 4 (preferred) to Tier 5 (non-preferred) if a generic equivalent becomes available or if new safety concerns arise. If your drug is moved to a higher Tier, your cost-share will increase. See pages 110, 111 and 112 for the amounts members pay for Preferred retail, mail service, and specialty drug purchases. Tier reassignments during the year are not considered benefit changes.
- **Under Standard Option,**
  - You may use the Retail Pharmacy Program, the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program to fill your prescriptions.
  - We use an open formulary. See page 103 for details.
  - The calendar year deductible does **not** apply to prescriptions filled through the Retail Pharmacy Program, the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program.
  - PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Basic Option,**
  - **You must use Preferred providers or the Specialty Drug Pharmacy Program in order to receive benefits. See page 21 for the exceptions to this requirement.** Our specialty drug pharmacy is a Preferred provider.
  - We use a managed formulary. Some drugs and supplies are excluded from coverage. See page 103 for details.
  - There is **no calendar year deductible**.
  - The Mail Service Prescription Drug Program is available only to members with primary Medicare Part B coverage.

We will send each new enrollee a combined prescription drug/Plan identification card. Standard Option members, and Basic Option members with primary Medicare Part B coverage, are eligible to use the Mail Service Prescription Drug Program and will also receive a mail service order form and a preaddressed reply envelope.

- **Who can write your prescriptions.** A physician or dentist licensed in the United States, Puerto Rico, or the U.S. Virgin Islands, or, in states that permit it, a licensed or certified physician assistant, nurse practitioner, or psychologist must write your prescriptions [see Section 5(i) for drugs purchased overseas].

- **Where you can obtain them.**

  Under Standard Option, you may fill prescriptions at a Preferred retail pharmacy, at a Non-preferred retail pharmacy, through our Mail Service Prescription Drug Program, or through the Specialty Drug Pharmacy Program. Under Standard Option, we pay a higher level of benefits when you use a Preferred retail pharmacy, our Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program. See page 151 for the definition of "specialty drugs."

  Under Basic Option, you must fill prescriptions only at a Preferred retail pharmacy or through the Specialty Drug Pharmacy Program, in order to receive benefits. If Medicare Part B is your primary coverage, you may also fill prescriptions through our Mail Service Prescription Drug Program. See page 151 for the definition of "specialty drugs."

  Note: The Mail Service Prescription Drug Program will not fill your prescription until you have obtained prior approval. CVS Caremark, the program administrator, will hold your prescription for you up to 30 days. If prior approval is not obtained within 30 days, your prescription will be returned to you along with a letter explaining the prior approval procedures.

  Under Standard Option and Basic Option

  Note: Both Preferred and Non-preferred retail pharmacies may offer options for ordering prescription drugs online. Drugs ordered online may be delivered to your home; however, these online orders are not a part of the Mail Service Prescription Drug Program, described on page 111.

  Note: Due to manufacturer restrictions, a small number of specialty drugs used to treat rare or uncommon conditions may be available only through a Preferred retail pharmacy. See page 110 for information about your cost-share for specialty drugs purchased at a Preferred retail pharmacy that are affected by these restrictions.

- **Under Standard Option, we use an open formulary.** This includes a list of preferred drugs selected to meet patient needs at a lower cost to us. If your physician believes a brand-name drug is necessary or there is no generic equivalent available, ask your physician to prescribe a brand-name drug from our preferred drug list. We may ask your doctor to substitute a preferred drug in order to help control costs. If you purchase a drug that is not on our preferred drug list, your cost will be higher. We cover drugs that require a prescription, whether or not they are on our preferred drug list. Your cooperation with our cost-savings efforts helps keep your premium affordable.

  Note: **Before filling your prescription, please check the preferred/non-preferred status of the drug.** Other than changes resulting from new drugs or safety issues, the preferred drug list is updated periodically during the year.

  Under Basic Option, we use a managed formulary for certain drug classes. This includes a limited list of preferred drugs selected to meet patient needs at a lower cost. If your physician believes a brand-name drug is necessary or when there is no generic equivalent available, ask your physician to prescribe a brand name drug from our preferred drug list. If you purchase a drug that is not on our preferred list, your cost will be higher. **If you purchase a drug in a class included in the managed formulary that is not on the managed formulary you will pay the full cost of that drug since that drug is not covered under your benefit.**

  Note: **Before filling your prescription, please check the preferred/non-preferred status of the drug.** Other than changes resulting from new drugs or safety issues, the preferred drug list is updated periodically during the year.

Note: Member cost-share for prescription drugs is determined by the tier to which a drug has been assigned. To determine the tier assignments for formulary drugs, we work with our Pharmacy and Medical Policy Committee, a group of physicians and pharmacists who are not employees or agents of, nor have financial interest in, the Blue Cross and Blue Shield Service Benefit Plan. The Committee meets quarterly to review new and existing drugs to assist us in our assessment of these drugs for safety and efficacy. Drugs determined to be of equal therapeutic value and similar safety and efficacy are then evaluated on the basis of cost. The Committee's recommendations, together with our evaluation of the relative cost of the drugs, determine the placement of formulary drugs on a specific tier. Using lower cost preferred drugs will provide you with a high quality, cost-effective prescription drug benefit.

Our payment levels are generally categorized as:

Tier 1: Includes generic drugs

Tier 2: Includes preferred brand-name drugs

Tier 3: Includes non-preferred brand-name drugs

Tier 4: Includes preferred specialty drugs

Tier 5: Includes non-preferred specialty drugs

You can view both the Standard Option and Basic Option formularies, which include the preferred drug list for each on our website at www.fepblue.org or request a copy by mail by calling 1-800-624-5060 (TDD: 1-800-624-5077). If you do not find your drug on the formulary or the preferred drug list, please call 1-800-624-5060. Any savings we receive on the cost of drugs purchased under this Plan from drug manufacturers are credited to the reserves held for this Plan.

- **Generic equivalents.**

  Generic equivalent drugs have the same active ingredients as their brand-name equivalents. By filling your prescriptions (or those of family members covered by the Plan) at a retail pharmacy, through the Specialty Drug Pharmacy Program, or, for Standard Option members and for Basic Option members with primary Medicare Part B, through the Mail Service Prescription Drug Program, you authorize the pharmacist to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a brand-name drug. Keep in mind that **Basic Option members must use Preferred providers in order to receive benefits.**

- **Why use generic drugs?** Generic drugs are generally lower cost drugs. Generic drugs have the same quality and strength as brand-name drugs and must meet the same strict standards for quality and effectiveness set by the U.S. Food and Drug Administration (FDA), as brand-name drugs.

  You can save money by using generic drugs. Keep in mind that doctors often have several medication options to treat their patients. If your brand-name drug does not have an equivalent generic drug, there may be a generic alternative drug available to treat your condition. You may want to talk with your doctor about generic drugs and how you can reduce your prescription drug costs. You or your doctor may request a brand-name drug even if a generic option is available. See Section 10, *Definitions*, for more information about generic alternatives and generic equivalents.

- **Disclosure of information.** As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including the names of your prescribing physicians, to any treating physicians or dispensing pharmacies.

- **These are the dispensing limitations.**

  Standard Option: Subject to manufacturer packaging and your prescriber's instructions, you may purchase **up to** a 90-day supply of covered drugs and supplies through the Retail Pharmacy Program or a 31- to 90-day supply through the Specialty Drug Pharmacy Program. You may purchase a supply of **more than** 21 days **up to** 90 days through the Mail Service Prescription Drug Program for a single copayment.

  Basic Option: When you fill Tier 1 (generic), Tier 2 (preferred brand-name), and Tier 3 (non-preferred brand-name) prescriptions at a Preferred retail pharmacy, you may purchase **up to** a 30-day supply for a single copayment, or **up to** a 90-day supply for additional copayments. When you fill Tier 4 and Tier 5 specialty drug prescriptions, you may purchase up to a 30-day supply through a Preferred retail pharmacy or the Specialty Drug Pharmacy Program. Members with primary Medicare Part B coverage may purchase a supply of **more than** 21 days **up to** 90 days through the Mail Service Prescription Drug Program for a single copayment.

  Note: Certain drugs such as narcotics may have additional FDA limits on the quantities that a pharmacy may dispense. In addition, pharmacy dispensing practices are regulated by the state where they are located and may also be determined by individual pharmacies. Due to safety requirements, some medications are dispensed as originally packaged by the manufacturer and we cannot make adjustments to the packaged quantity or otherwise open or split packages to create 90-day supplies of those medications. **In most cases, refills cannot be obtained until 75% of the prescription has been used.** Call us or visit our website if you have any questions about dispensing limits. Please note that in the event of a national or other emergency, or if you are a reservist or National Guard member who is called to active military duty, you should contact us regarding your prescription drug needs. See the contact information below.

- **Important contact information.**

  Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077)

  Mail Service Prescription Drug Program: 1-800-262-7890 (TDD: 1-800-216-5343);

  Specialty Drug Pharmacy Program: 1-888-346-3731 (TDD: 1-877-853-9549); or www.fepblue.org.

Patient Safety and Quality Monitoring (PSQM)

We have a special program to promote patient safety and monitor health care quality. Our Patient Safety and Quality Monitoring (PSQM) program features a set of closely aligned programs that are designed to promote the safe and appropriate use of medications. Examples of these programs include:

- Prior approval – As described below, this program requires that approval be obtained for certain prescription drugs and supplies before we provide benefits for them.
- Safety checks – Before your prescription is filled, we perform quality and safety checks for usage precautions, drug interactions, drug duplication, excessive use, and frequency of refills.
- Quantity allowances – Specific allowances for several medications are based on FDA-approved recommendations, clinical studies, and manufacturer guidelines.

For more information about our PSQM program, including listings of drugs subject to prior approval or quantity allowances, visit our website at www.fepblue.org or call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077).

Prior Approval

As part of our Patient Safety and Quality Monitoring (PSQM) program (see above), **you must make sure that your physician obtains prior approval for certain prescription drugs and supplies in order to use your prescription drug coverage**. In providing prior approval, we may limit benefits to quantities prescribed in accordance with accepted standards of medical, dental, or psychiatric practice in the United States. **Prior approval must be renewed periodically.** To obtain a list of these drugs and supplies and to obtain prior approval request forms, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077). You can also obtain the list through our website at www.fepblue.org. Please read Section 3 for more information about prior approval.

Please note that updates to the list of drugs and supplies requiring prior approval are made periodically during the year. New drugs and supplies may be added to the list and prior approval criteria may change. Changes to the prior approval list or to prior approval criteria are not considered benefit changes.

Note: If your prescription requires prior approval and you have not yet obtained prior approval, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.

Covered medications and supplies

Standard Option Generic Incentive Program

Your cost-share will be waived for the first 4 generic prescriptions filled (and/or refills ordered) per drug per calendar year if you purchase a brand-name drug listed below while a member of the Service Benefit Plan and then change to a corresponding generic drug replacement while still a member of the Plan.

Preferred Retail Pharmacy

- Your 20% coinsurance amount (15% when Medicare Part B is primary) is waived for the first 4 generic drug replacements filled (and/or refills ordered) per drug per calendar year. You may receive up to 4 coinsurance waivers per drug change per year.
- If you switch from one generic drug to another, you will be responsible for your coinsurance amount.
- Both the brand-name drug and its corresponding generic drug replacement must be purchased during the same calendar year.

Mail Service Prescription Drug Program

- Your $15 copayment ($10 when Medicare Part B is primary) is waived for the first 4 generic drug replacements filled (and/or refills ordered) per drug per calendar year. You may receive up to 4 copayment waivers per drug change per year.
- If you switch from one generic drug to another, you will be responsible for the copayment.
- Both the brand-name drug and its corresponding generic drug replacement must be purchased during the same calendar year.

If you take one of these brand-name drugs . . .	And change to one of these generic drug replacements . . .	
Actonel, Boniva, Fosamax	Alendronate, ibandronate or risendronate	**You will receive your first 4 prescription fills (or refills) of the corresponding generic drug at no charge.** **(Please see the Standard Option Generic Incentive Program description above for complete information.)**
Aciphex, Dexilant (formerly Kapidex), Nexium, Prevacid, Prilosec, Protonix, Zegerid	omeprazole, lansoprazole, pantoprazole, rabeprazole or esomeprazole	
Ambien CR, Lunesta, Rozerem	zaleplon, zolpidem, eszopiclone, or zolpidem extended-release	
Advicor, Altoprev, Crestor, Lescol, Lescol XL, Lipitor, Livalo, Mevacor, Pravachol, Simcor, Vytorin, Zocor	simvastatin, pravastatin, lovastatin, atorvastatin, or fluvastatin	
Caduet	simvastatin, pravastatin, lovastatin, atorvastatin, fluvastatin, amlodipine, or amlodipine/atorvastatin	
Famvir	famciclovir	
Valtrex	valacyclovir	
Atacand, Avapro, Benicar, Cozaar, Diovan, Micardis, Teveten	losartan, candesartan, irbesartan, eprosartan, telmisartan, or valsartan	
Atacand HCT, Avalide, Benicar HCT, Diovan HCT, Hyzaar, Micardis HCT, Teveten HCT	losartan HCT, candesartan HCT, irbesartan HCT, eprosartan HCT, valsartan HCT, or telmisarten HCT	
Detrol, Oxytrol, Sanctura, Toviaz, Vesicare	tolterodine, oxybutynin, oxybutynin extended-release, or trospium	
Detrol LA, Enablex, Sanctura XR	oxybutynin extended-release, trospium extended-release, or tolterodine extended release	
Betimol, Istalol, Timoptic-XE	timolol maleate ophthalmic	

Please note the list of eligible generic drug replacements may change if additional generic drugs corresponding to the listed brand-name drugs become available during the year. For the most up-to-date information, please visit our Pharmacy Program website through www.fepblue.org.

Covered medications and supplies – continued on next page

Benefit Description	You Pay	
Note: **For Standard Option, we state whether or not the calendar year deductible applies for each benefit listed in this Section. There is no calendar year deductible under Basic Option.**		
Covered medications and supplies *(continued)*	**Standard Option**	**Basic Option**
• Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase ***Note:*** See page 109 for our coverage of medicines to promote better health as recommended under the Affordable Care Act. ***Note:*** See Section 5(a), page 61, for our coverage of medical foods for children and for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube. • Insulin, diabetic test strips, and lancets ***Note:*** See page 60 for our coverage of insulin pumps. • Needles and disposable syringes for the administration of covered medications • Clotting factors and anti-inhibitor complexes for the treatment of hemophilia • Drugs to aid smoking and tobacco cessation that require a prescription by Federal law ***Note:*** We provide benefits for over-the-counter (OTC) smoking and tobacco cessation medications only as described on page 112-113. ***Note:*** You may be eligible to receive smoking and tobacco cessation medications at no charge. See page 112 for more information. • ***Note:*** Drugs for the diagnosis and treatment of infertility, except as described on page 114 • Drugs to treat gender identity/gender dysphoria (Gonadotropin-releasing hormone (GnRH) antagonists and testosterones are limited to members age 16 and over.) • Contraceptive drugs and devices, limited to: – Diaphragms and contraceptive rings – Injectable contraceptives – Intrauterine devices (IUDs) – Implantable contraceptives – Oral and transdermal contraceptives ***Note:*** We waive your cost-share for generic contraceptives and for brand-name contraceptives that have no generic equivalent or generic alternative, when you purchase them at a Preferred retail pharmacy or, for Standard Option members and Basic Option members with primary Medicare Part B, through the Mail Service Prescription Drug Program. See pages 110 and 111 for details.	See page 106 and pages 108-113	See page 106 and pages 108-113

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	You Pay	
	Standard Option	**Basic Option**
• Over-the-counter (OTC) contraceptive drugs and devices, for women only, limited to: – Emergency contraceptive pills – Female condoms – Spermicides – Sponges ***Note:*** We provide benefits in full for OTC contraceptive drugs and devices for women only when the contraceptives meet FDA standards for OTC products. To receive benefits, you must use a Preferred retail pharmacy and present the pharmacist with a written prescription from your physician.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges	Preferred retail pharmacy: Nothing Non-preferred retail pharmacy: You pay all charges
Routine immunizations when provided by a Preferred retail pharmacy that participates in our vaccine network (see below) and administered in compliance with applicable state law and pharmacy certification requirements, limited to: • Herpes zoster (shingles) vaccines • Human papillomavirus (HPV) vaccines • Influenza (flu) vaccines • Pneumococcal vaccines • Meningococcal vaccines ***Note:*** Our vaccine network is a network of Preferred retail pharmacies that have agreements with us to administer one or more of the routine immunizations listed above. Check with your pharmacy or call our Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) to see which vaccines your pharmacy can provide.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges (except as noted below) ***Note:*** You pay nothing for Influenza (flu) vaccines obtained at Non-preferred retail pharmacies.	Preferred retail pharmacy: Nothing Non-preferred retail pharmacy: You pay all charges (except as noted below) ***Note:*** You pay nothing for Influenza (flu) vaccines obtained at Non-preferred retail pharmacies.
Diabetic Meter Program Members with diabetes may obtain one glucose meter kit per calendar year at no cost through our Diabetic Meter Program. To use this program, you must call the number listed below and request one of the eligible types of meters. The types of glucose meter kits available through the program are subject to change. To order your free glucose meter kit, call us toll-free at 1-855-582-2024, Monday through Friday, from 9 a.m. to 7 p.m., Eastern Time, or visit our website at www.fepblue.org. The selected meter kit will be sent to you within 7 to 10 days of your request. ***Note:*** Contact your physician to obtain a new prescription for the test strips and lancets to use with the new meter. Benefits will be provided for the test strips at Tier 2 (preferred brand-name) benefit payment levels if you purchase brand-name strips at a Preferred retail pharmacy or, for Standard Option members and Basic Option members with primary Medicare Part B, through the Mail Service Prescription Drug Program. See pages 110 and 111 for more information.	Nothing for a glucose meter kit ordered through the Diabetic Meter Program	Nothing for a glucose meter kit ordered through the Diabetic Meter Program

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	You Pay	
	Standard Option	**Basic Option**
Medicines to promote better health as recommended under the Patient Protection and Affordable Care Act (the "Affordable Care Act"), limited to: • Iron supplements for children from age 6 months through 12 months • Oral fluoride supplements for children from age 6 months through 5 years • Folic acid supplements, 0.4 mg to 0.8 mg, for women capable of pregnancy • Vitamin D supplements for adults, age 65 and over, limited to a recommended daily allowance of 600-800 international units (I.U.s) per day • Low-dose aspirin (81 mg per day) for pregnant women at risk for preeclampsia • Aspirin for men age 45 through 79 and women age 55 through 79 ***Note:*** Benefits are not available for *Tylenol, Ibuprofen, Aleve,* etc. ***Note:*** Benefits for the medicines listed above are subject to the dispensing limitations described on page 105 and are limited to recommended prescribed limits. ***Note:*** To receive benefits, you must use a Preferred retail pharmacy and present a written prescription from your physician to the pharmacist. ***Note:*** A complete list of USPSTF-recommended preventive care services is available online at: www.healthcare.gov/what-are-my-preventive-care-benefits. See pages 42-47 in Section 5(a) for information about other covered preventive care services. ***Note:*** See page 112 for our coverage of smoking and tobacco cessation medicines.	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges	Preferred retail pharmacy: Nothing Non-preferred retail pharmacy: You pay all charges
Generic medicines (limited to tamoxifen and raloxifene) to reduce breast cancer risk for women, age 35 or over, who have not been diagnosed with any form of breast cancer ***Note:*** Your physician must send a completed Coverage Request Form to CVS Caremark before you fill the prescription. Call CVS Caremark at 1-800-262-7890 to request this form.	Preferred retail pharmacy: Nothing (no deductible) Mail Service Prescription Drug Program: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges	Preferred retail pharmacy: Nothing Non-preferred retail pharmacy: You pay all charges **When Medicare Part B is primary, you pay the following:** Mail Service Prescription Drug Program: Nothing

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	You Pay	
	Standard Option	**Basic Option**
Here is how to obtain your prescription drugs and supplies: **Preferred Retail Pharmacies** • Make sure you have your Plan ID card when you are ready to purchase your prescription • Go to any Preferred retail pharmacy, or • Visit the website of your Preferred retail pharmacy to request your prescriptions • For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our website, www.fepblue.org ***Note:*** Retail pharmacies that are Preferred for prescription drugs are not necessarily Preferred for durable medical equipment (DME) and medical supplies. To receive Preferred benefits for DME and covered medical supplies, you must use a Preferred DME or medical supply provider. See Section 5(a) for the benefit levels that apply to DME and medical supplies. ***Note:*** Benefits for Tier 4 and Tier 5 specialty drugs purchased at a Preferred retail pharmacy are limited to one purchase of up to a 30-day supply for each prescription dispensed. All refills must be obtained through the Specialty Drug Pharmacy Program. See page 112 for more information. ***Note:*** For prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility, we provide benefits as shown on this page for drugs obtained from a retail pharmacy, as long as the pharmacy supplying the prescription drugs to the facility is a Preferred pharmacy. **For benefit information about prescription drugs supplied by Non-preferred retail pharmacies, please refer to page 111.** ***Note:*** For a list of the Preferred Network Long Term Care pharmacies, call 1-800-624-5060 (TDD: 1-800-624-5077). ***Note:*** For coordination of benefits purposes, if you need a statement of Preferred retail pharmacy benefits in order to file claims with your other coverage when this Plan is the primary payor, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our website at www.fepblue.org. ***Note:*** We waive your cost-share for available forms of generic contraceptives and for brand-name contraceptives that have no generic equivalent or generic alternative.	Tier 1 (generic drug): 20% of the Plan allowance (no deductible) ***Note:*** You pay 15% of the Plan allowance when Medicare Part B is primary. ***Note:*** You may be eligible to receive your first 4 generic prescriptions filled (and/or refills ordered) at no charge when you change from certain brand-name drugs to a corresponding generic drug replacement. See page 106 for complete information. Tier 2 (preferred brand-name drug): 30% of the Plan allowance (no deductible) Tier 3 (non-preferred brand-name drug): 45% of the Plan allowance (no deductible) Tier 4 (preferred specialty drug): 30% of the Plan allowance (no deductible), limited to one purchase of up to a 30-day supply Tier 5 (non-preferred specialty drug): 30% of the Plan allowance (no deductible), limited to one purchase of up to a 30-day supply	Tier 1 (generic drug): $10 copayment for each purchase of up to a 30-day supply ($30 copayment for 90-day supply) Tier 2 (preferred brand-name drug): $50 copayment for each purchase of up to a 30-day supply ($150 copayment for 90-day supply) Tier 3 (non-preferred brand-name drug): 60% of Plan allowance ($65 minimum) for each purchase of up to a 30-day supply ($195 minimum for 90-day supply) Tier 4 (preferred specialty drug): $65 copayment for up to a 30-day supply only Tier 5 (non-preferred specialty drug): $90 copayment for up to a 30-day supply only **When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): see above Tier 2 (preferred brand-name drug): $45 copayment for each purchase of up to a 30-day supply ($135 copayment for 90-day supply) Tier 3 (non-preferred brand-name drug): 50% of Plan allowance ($55 minimum) for each purchase of up to a 30-day supply ($165 minimum for 90-day supply) Tier 4 (preferred specialty drug): $60 copayment for up to a 30-day supply only Tier 5 (non-preferred specialty drug): $80 copayment for up to a 30-day supply only

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	You Pay	
	Standard Option	**Basic Option**
Non-preferred Retail Pharmacies	45% of the Plan allowance (Average wholesale price – AWP), plus any difference between our allowance and the billed amount (no deductible) ***Note:*** If you use a Non-preferred retail pharmacy, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.	*All charges*
Mail Service Prescription Drug Program If your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you can use this service for your prescriptions and refills. Please refer to Section 7 for instructions on how to use the Mail Service Prescription Drug Program. ***Note:*** Not all drugs are available through the Mail Service Prescription Drug Program. There are no specialty drugs available through the Mail Service Program. ***Note:*** Please refer to page 112 for information about the Specialty Drug Pharmacy Program. ***Note:*** We waive your cost-share for available forms of generic contraceptives and for brand-name contraceptives that have no generic equivalent or generic alternative. ***Contact Us:*** If you have any questions about this program, or need assistance with your Mail Service drug orders, please call 1-800-262-7890 (TDD: 1-800-216-5343). ***Note:*** If the cost of your prescription is less than your copayment, you pay only the cost of your prescription. The Mail Service Prescription Drug Program will charge you the lesser of the prescription cost or the copayment when you place your order. If you have already sent in your copayment, they will credit your account with any difference.	Tier 1 (generic drug): $15 copayment (no deductible) ***Note:*** You pay a $10 copayment per generic prescription filled (and/or refill ordered) when Medicare Part B is primary. ***Note:*** You may be eligible to receive your first 4 generic prescriptions filled (and/or refills ordered) at no charge when you change from certain brand-name drugs to a corresponding generic drug replacement. See page 106 for complete information. Tier 2 (preferred brand-name drug): $80 copayment (no deductible) Tier 3 (non-preferred brand-name drug): $105 copayment (no deductible) ***Note:*** The copayment amounts listed above for brand-name drugs only apply to your first 30 brand-name prescriptions filled (and/or refills ordered) per calendar year; you pay a $50 copayment per brand-name prescription/refill thereafter.	**When Medicare Part B is primary, you pay the following:** Tier 1 (generic drug): $20 copayment Tier 2 (preferred brand-name drug): $90 copayment Tier 3 (non-preferred brand-name drug): $115 copayment ***Note:*** See page 24 for information about drugs and supplies that require prior approval. You must obtain prior approval before Mail Service will fill your prescription. See pages 24 and 105. When Medicare Part B is not primary: No benefits ***Note:*** Although you do not have access to the Mail Service Prescription Drug Program, you may request home delivery of prescription drugs you purchase from Preferred retail pharmacies offering options for online ordering. See page 110 of this Section for our payment levels for drugs obtained through Preferred retail pharmacies.

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	You Pay	
	Standard Option	**Basic Option**
Specialty Drug Pharmacy Program We cover specialty drugs that are listed on the Service Benefit Plan Specialty Drug List. This list is subject to change. For the most up-to-date list, call the number below or visit our website, www.fepblue.org. (See page 151 for the definition of "specialty drugs.") Each time you order a new specialty drug or refill, a Specialty Drug pharmacy representative will work with you to arrange a delivery time and location that is most convenient for you, as well as ask you about any side effects you may be experiencing. See page 132 for more details about the Program. ***Note:*** Benefits for the first three fills of each Tier 4 or Tier 5 specialty drug are limited to a 30-day supply. Benefits are available for a 90-day supply after the third fill. ***Note:*** Due to manufacturer restrictions, a small number of specialty drugs may only be available through a Preferred retail pharmacy. You will be responsible for paying only the copayments shown here for specialty drugs affected by these restrictions. ***Contact Us:*** If you have any questions about this program, or need assistance with your specialty drug orders, please call 1-888-346-3731 (TDD: 1-877-853-9549).	Specialty Drug Pharmacy Program: Tier 4 (preferred specialty drug): $35 copayment for up to a 30-day supply ($95 copayment for a 31- to 90-day supply) (no deductible) Tier 5 (non-preferred specialty drug): $55 copayment for up to a 30-day supply ($155 copayment for a 31- to 90-day supply) (no deductible) ***Note:*** The copayments listed above for 31- to 90-day supplies of specialty drugs apply to the first 30 prescriptions refilled or ordered per calendar year; thereafter, your copayment is $50 for each 31- to 90-day supply.	Specialty Drug Pharmacy Program: Tier 4 (preferred specialty drug): $55 copayment for up to a 30-day supply ($165 copayment for a 31- to 90-day supply) Tier 5 (non-preferred specialty drug): $80 copayment for up to a 30-day supply ($240 copayment for a 31- to 90-day supply) **When Medicare Part B is primary, you pay the following:** Tier 4 (preferred specialty drug): $50 copayment for up to a 30-day supply ($140 copayment for a 31- to 90-day supply) Tier 5 (non-preferred specialty drug): $70 copayment for up to a 30-day supply ($195 copayment for a 31- to 90-day supply)
Smoking and Tobacco Cessation Medications If you are age 18 or over, you may be eligible to obtain specific prescription generic and brand-name smoking and tobacco cessation medications at no charge. Additionally, you may be eligible to obtain over-the-counter (OTC) smoking and tobacco cessation medications, prescribed by your physician, at no charge. These benefits are only available when you use a Preferred retail pharmacy. To qualify, complete the Blue Health Assessment (BHA) questionnaire indicating you are a tobacco user, and create a Tobacco Cessation Quit Plan using our Online Health Coach. For more information, see pages 119 and 120. The following medications are covered through this program: • Generic medications available by prescription: – Bupropion ER 150 mg tablet – Bupropion SR 150 mg tablet • Brand-name medications available by prescription: – Chantix 0.5 mg tablet – Chantix 1 mg cont monthly pack	Preferred retail pharmacy: Nothing (no deductible) Non-preferred retail pharmacy: You pay all charges	Preferred retail pharmacy: Nothing Non-preferred retail pharmacy: You pay all charges

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	You Pay	
	Standard Option	**Basic Option**
– Chantix 1 mg tablet – Chantix starting monthly pack – Nicotrol cartridge inhaler – Nicotrol NS Spray 10 mg/ml • Over-the-counter (OTC) medications ***Note:*** To receive benefits for over-the-counter (OTC) smoking and tobacco cessation medications, you must have a physician's prescription for each OTC medication that must be filled by a pharmacist at a Preferred retail pharmacy. ***Note:*** These benefits apply only when all of the criteria listed above are met. Regular prescription drug benefits will apply to purchases of smoking and tobacco cessation medications not meeting these criteria. Benefits are not available for over-the-counter (OTC) smoking and tobacco cessation medications except as described above. ***Note:*** See page 64 for our coverage of smoking and tobacco cessation treatment, counseling, and classes.	See page 112	See page 112
Drugs from other sources • Covered prescription drugs and supplies not obtained at a retail pharmacy, through the Specialty Drug Pharmacy Program, or, for Standard Option members and Basic Option members with primary Medicare Part B, through the Mail Service Prescription Drug Program ***Note:*** We cover drugs and supplies purchased overseas as shown here, as long as they are the equivalent to drugs and supplies that by Federal law of the United States require a prescription. Please refer to pages 124-125 in Section 5(i) for more information. ***Note:*** For covered prescription drugs and supplies purchased outside of the United States, Puerto Rico, and the U.S. Virgin Islands, please submit claims on an Overseas Claim Form. See Section 5(i) for information on how to file claims for overseas services. • Please refer to the Sections indicated for additional benefit information when you purchase drugs from a: – Physician's office – Section 5(a) – Facility (inpatient or outpatient) – Section 5(c) – Hospice agency – Section 5(c) • Please refer to page 110 for prescription drugs obtained from a Preferred retail pharmacy, that are billed for by a skilled nursing facility, nursing home, or extended care facility	Preferred: 15% of the Plan allowance (deductible applies) Participating/Member: 35% of the Plan allowance (deductible applies) Non-participating/Non-member: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Member or Non-participating/Non-member: You pay all charges

Covered medications and supplies – continued on next page

Covered medications and supplies *(continued)*	**You Pay**	
	Standard Option	**Basic Option**
Not covered: • *Medical supplies such as dressings and antiseptics* • *Drugs and supplies for cosmetic purposes* • *Drugs and supplies for weight loss* • *Drugs for orthodontic care, dental implants, and periodontal disease* • *Drugs used in conjunction with assisted reproductive technology (ART) and assisted insemination procedures* • *Insulin and diabetic supplies except when obtained from a retail pharmacy or through the Mail Service Prescription Drug Program, or except when Medicare Part B is primary. See pages 60 and 107.* • *Medications and orally taken nutritional supplements that do not require a prescription under Federal law even if your doctor prescribes them or if a prescription is required under your state law* **Note:** *See page 109 for our coverage of medicines recommended under the Affordable Care Act and page 112-113 for smoking and tobacco cessation medications.* **Note:** *See Section 5(a), page 61 for our coverage of medical foods for children and for our coverage of medical foods and nutritional supplements when administered by catheter or nasogastric tube.* • *Drugs for which prior approval has been denied or not obtained* • *Infant formula other than described on page 61* • *Drugs and supplies related to sexual dysfunction or sexual inadequacy* • *Drugs and covered-drug-related supplies for the treatment of gender identity/gender dysphoria if not obtained from a retail pharmacy or through the Mail Service Prescription Drug Program or Specialty Drug Pharmacy Program as described on page 107* • *Drugs purchased through the mail or internet from pharmacies outside the United States by members located in the United States* • *Over-the-counter (OTC) contraceptive drugs and devices, except as described on page 107* • *Drugs used to terminate pregnancy* • *Sublingual allergy desensitization drugs, except as described on page 53*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be the primary payor for any covered services and your FEDVIP Plan will be secondary to your FEHB Plan. See Section 9, *Coordinating benefits with Medicare and other coverage*, for additional information.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- ***Note:*** We cover inpatient and outpatient hospital care, as well as anesthesia administered at the facility, to treat children up to age 22 with severe dental caries. We cover these services for other types of dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient (even if the dental procedure itself is not covered). See Section 5(c) for inpatient and outpatient hospital benefits.
- **Under Standard Option,**
  - The calendar year deductible of $350 per person ($700 per Self Plus One or Self and Family enrollment) applies only to the accidental injury benefit below.
- **Under Basic Option,**
  - There is **no calendar year deductible**.
  - **You must use Preferred providers in order to receive benefits, except in cases of dental care resulting from an accidental injury as described below.**

Accidental injury benefit	You Pay	
	Standard Option	**Basic Option**
We provide benefits for services, supplies, or appliances for dental care necessary to promptly repair injury to sound natural teeth required as a result of, and directly related to, an accidental injury. To determine benefit coverage, we may require documentation of the condition of your teeth before the accidental injury, documentation of the injury from your provider(s), and a treatment plan for your dental care. We may request updated treatment plans as your treatment progresses. ***Note:*** An **accidental injury** is an injury caused by an external force or element such as a blow or fall and that requires immediate attention. Injuries to the teeth while eating are not considered accidental injuries. ***Note:*** A **sound natural tooth** is a tooth that is whole or properly restored (restoration with amalgams or resin-based composite fillings only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.	Preferred: 15% of the Plan allowance (deductible applies) Participating: 35% of the Plan allowance (deductible applies) Non-participating: 35% of the Plan allowance (deductible applies), plus any difference between our allowance and the billed amount ***Note:*** Under Standard Option, we first provide benefits as shown in the Schedule of Dental Allowances on the following pages. We then pay benefits as shown here for any balances.	$30 copayment per visit ***Note:*** **We provide benefits for accidental dental injury care in cases of medical emergency when performed by Preferred or Non-preferred providers.** See Section 5(d) for the criteria we use to determine if emergency care is required. You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.

Dental benefits

What is Covered

Standard Option dental benefits are presented in the chart beginning below and continuing on the following pages.

Basic Option dental benefits appear on page 118.

Note: See Section 5(b) for our benefits for Oral and maxillofacial surgery, and Section 5(c) for our benefits for hospital services (inpatient/outpatient) in connection with dental services, available under both Standard Option and Basic Option.

Preferred Dental Network

All Local Plans contract with Preferred dentists who are available in most areas. Preferred dentists agree to accept a negotiated, discounted amount called the Maximum Allowable Charge (MAC) as payment in full for the following services. They will also file your dental claims for you. Under Standard Option, you are responsible, as an out-of-pocket expense, for the difference between the amount specified in this Schedule of Dental Allowances and the MAC. To find a Preferred dentist near you, visit www.fepblue.org/provider to use our National Doctor & Hospital Finder, or call us at the customer service number on the back of your ID card. You can also call us to obtain a copy of the applicable MAC listing.

Note: Dentists and oral surgeons who are in our Preferred Dental Network for routine dental care are not necessarily Preferred providers for other services covered by this Plan under other benefit provisions (such as the surgical benefit for oral and maxillofacial surgery). Call us at the customer service number on the back of your ID card to verify that your provider is Preferred for the type of care (e.g., routine dental care or oral surgery) you are scheduled to receive.

Standard Option dental benefits

Under Standard Option, we pay billed charges for the following services, up to the amounts shown per service as listed in the Schedule of Dental Allowances below and on the following pages. This is a complete list of dental services covered under this benefit for Standard Option. There are no deductibles, copayments, or coinsurance. When you use Non-preferred dentists, you pay all charges in excess of the listed fee schedule amounts. For Preferred dentists, you pay the difference between the fee schedule amount and the MAC (see above).

Standard Option dental benefits	Standard Option Only		
Covered service	**We pay**		**You pay**
Clinical oral evaluations	**To age 13**	**Age 13 and over**	
Periodic oral evaluation *(up to 2 per person per calendar year)*	$12	$8	All charges in excess of the scheduled amounts listed to the left
Limited oral evaluation	$14	$9	
Comprehensive oral evaluation	$14	$9	***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Detailed and extensive oral evaluation	$14	$9	

Dental benefits – continued on next page

Standard Option dental benefits *(continued)*	**Standard Option Only**		
Covered service	**We pay**		**You pay**
Diagnostic imaging	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left ***Note:*** For services performed by dentists and oral surgeons in our Preferred Dental Network, you pay the difference between the amounts listed to the left and the Maximum Allowable Charge (MAC).
Intraoral complete series	$36	$22	
Intraoral periapical first image	$7	$5	
Intraoral periapical each additional image	$4	$3	
Intraoral occlusal image	$12	$7	
Extraoral first image	$16	$10	
Extraoral each additional image	$6	$4	
Bitewing – single image	$9	$6	
Bitewings – two images	$14	$9	
Bitewings – four images	$19	$12	
Vertical bitewings	$12	$7	
Posterior-anterior or lateral skull and facial bone survey image	$45	$28	
Panoramic image	$36	$23	
Palliative treatment			
Palliative treatment of dental pain – minor procedure	$24	$15	
Protective restoration	$24	$15	
Preventive			
Prophylaxis – adult *(up to 2 per person per calendar year)*	---	$16	
Prophylaxis – child *(up to 2 per person per calendar year)*	$22	$14	
Topical application of fluoride or fluoride varnish	$13	$8	
Not covered: Any service not specifically listed above	*Nothing*	*Nothing*	*All charges*

Dental benefits – continued on next page

Basic Option dental benefits

Under Basic Option, we provide benefits for the services listed below. You pay a $30 copayment for each evaluation, and we pay any balances up to the Maximum Allowable Charge (MAC). This is a complete list of dental services covered under this benefit for Basic Option. You **must** use a Preferred dentist in order to receive benefits. For a list of Preferred dentists, visit www.fepblue.org/provider to use our National Doctor & Hospital Finder, or call us at the customer service number on the back of your ID card.

Basic Option dental benefits	Basic Option Only	
Covered service	**We pay**	**You pay**
Clinical oral evaluations Periodic oral evaluation* Limited oral evaluation Comprehensive oral evaluation* *Benefits are limited to a combined total of 2 evaluations per person per calendar year	Preferred: All charges in excess of your $30 copayment Participating/Non-participating: Nothing	Preferred: $30 copayment per evaluation Participating/Non-participating: You pay all charges
Diagnostic imaging Intraoral – complete series including bitewings *(limited to 1 complete series every 3 years)* Bitewing – single image* Bitewings – two images* Bitewings – four images* *Benefits are limited to a combined total of 4 images per person per calendar year		
Preventive Prophylaxis – adult *(up to 2 per calendar year)* Prophylaxis – child *(up to 2 per calendar year)* Topical application of fluoride or fluoride varnish – for children only *(up to 2 per calendar year)* Sealant – per tooth, first and second molars only *(once per tooth for children up to age 16 only)*		
Not covered: Any service not specifically listed above	*Nothing*	*All charges*

Section 5(h). Special features

Special feature	Description
Health Tools	Stay connected to your health and get the answers you need when you need them by using Health Tools 24 hours a day, 365 days a year. Go to www.fepblue.org or call 1-888-258-3432 toll-free to check out these valuable easy-to-use services: • Talk directly with a **Registered Nurse** any time of the day or night via telephone, secure email, or live chat. Ask questions and get medical advice. Please keep in mind that benefits for any health care services you may seek after using Health Tools are subject to the terms of your coverage under this Plan. • **Personal Health Record** – Access your secure online personal health record for information such as the medications you're taking, recent test results, and medical appointments. Update, store, and track health-related information at any time. • **Blue Health Assessment** – Complete this online health and lifestyle questionnaire and receive additional assistance with your health care expenses. See page 120 for complete information. • **Tobacco Cessation Incentive Program** – If you are age 18 or over and would like to quit smoking, you can participate in this program and receive tobacco cessation products at no charge. Start by completing the Blue Health Assessment (BHA) questionnaire indicating you are a tobacco user, and create a Tobacco Cessation Quit Plan using our Online Health Coach. You will then be eligible to receive certain smoking and tobacco cessation medications at no charge. Both prescription and over-the-counter (OTC) tobacco cessation products obtained from a Preferred retail pharmacy are included in this program. See pages 112-113 for more information. • **My Multimedia Health Library** offers an extensive variety of educational tools using videos, recorded messages, and colorful online material that provide up-to-date information about a wide range of health-related topics. • **Benefits Statements** – Access quarterly and annual statements of recent medical and pharmacy claims and out-of-pocket costs for each family member.
Services for the deaf and hearing impaired	All Blue Cross and Blue Shield Plans provide TDD access for the hearing impaired to access information and receive answers to their questions.
Web accessibility for the visually impaired	Our website, www.fepblue.org, adheres to the most current Section 508 Web accessibility standards to ensure that visitors with visual impairments can use the site with ease.
Travel benefit/services overseas	Please refer to Section 5(i) for benefit and claims information for care you receive outside the United States, Puerto Rico, and the U.S. Virgin Islands.
Healthy Families	Our Healthy Families suite of resources is for families with children and teens, ages 2 to 19. Healthy Families provides activities and tools to help parents teach their children about weight management, nutrition, physical activity, and personal wellbeing. For more information, go to www.fepblue.org.
***WalkingWorks*® Wellness Program**	*WalkingWorks*® can help you walk your way to better health through online tools and resources that encourage you to incorporate walking into your daily routine and to set – and achieve – personal wellness goals. Receive a pedometer to count your daily steps and then record your progress with the online *WalkingWorks* tracking tool. Learn more at www.fepblue.org and start walking your way to better health. If you do not have access to the internet, please call us at 1-888-706-2583. *WalkingWorks* was developed in cooperation with the President's Council on Physical Fitness and Sports.

Special features – continued on next page

Blue Health Assessment

The **Blue Health Assessment (BHA)** questionnaire is an easy and engaging online health evaluation program which can be completed in 10-15 minutes. Your BHA answers are evaluated to create a unique health action plan. Based on the results of your BHA, you can select personalized goals, receive supportive advice, and easily track your progress through our Online Health Coach.

When you complete your BHA, you are entitled to receive a $50 health account to be used for most qualified medical expenses. For those with Self Plus One or Self and Family coverage, up to two adult members, age 18 or over, are eligible for the $50 health account. We will send each eligible member a debit card to access his or her account. Please keep your card for future use even if you use all of your health account dollars; you may be eligible for wellness incentives in subsequent benefit years. We do not send new cards to continuing participants until the card expires. If you leave the Service Benefit Plan, any money remaining in your account will be forfeited.

In addition to the $50 health account, you are entitled to receive a maximum of $120 in additional credit to your health account for achieving up to three personalized goals. After completing the BHA, you may access the Online Health Coach to set personalized goals designed to improve your health through increased exercise, healthier nutrition habits, managing your weight, reduced stress, better emotional health, or goals that focus on managing a specific condition. We will add $40 to your health account for each goal achieved, up to a maximum of three goals per year. By completing the BHA and a maximum of three health goals, you can earn up to a total of $170 in health account dollars. You must complete the BHA and your selected goals during the calendar year in order to receive these incentives.

Health account dollars are available only when you complete goals related to exercise, nutrition, weight management, stress, emotional health, heart disease, heart failure, chronic obstructive pulmonary disease (COPD) and asthma and are limited to a maximum of three completed goals per calendar year.

Note: In order to receive your incentives, **you must complete all eligible activities no later than December 31, 2016**. Please allow ample time to complete all activities by this date.

Visit our website, www.fepblue.org, for more information and to complete the BHA so you can receive your individualized results and begin working toward achieving your goals. **You may also request a printed BHA** by calling 1-888-258-3432 toll-free.

Diabetes Management Incentive Program

The **Diabetes Management Incentive Program** is designed to provide critical health education to people with diabetes, to help assist people with diabetes in improving their blood sugar control, and help manage or slow the progression of complications related to diabetes. Through this program you can earn a maximum of $75 toward a health account to be used for most qualified medical expenses. To qualify for the Diabetes Management Incentive Program, you must be age 18 or over and complete the Blue Health Assessment (BHA) questionnaire indicating you have diabetes. The BHA is available on our website, www.fepblue.org. For those with Self Plus One or Self and Family coverage, this incentive program is limited to two adult members.

The following activities are rewarded through this program:

- $10 for having your A1c test performed by a covered provider (maximum of 2 per year)
- $5 for reporting A1c levels to the Diabetes Management Incentive Program via our website, www.fepblue.org (maximum of 2 per year)
- $10 for receiving diabetic glucose test strips through our pharmacy program (maximum of 4 per year)
- $10 for receiving a diabetic foot exam from a covered provider (maximum of 1 per year)

You can also receive a maximum of 1 of the following 3 rewards:

- $20 for enrolling in a diabetes disease management program (maximum of 1 per year)
- $20 for receiving a diabetic education visit from a covered provider (maximum of 1 per year)
- $5 for completing a web-based diabetes education quiz on our website, www.fepblue.org (maximum of 4 per year)

Note: Once you earn the maximum of $75 through this program for the calendar year, additional eligible activities are encouraged but will not be rewarded.

Note: For more information about this program, including eligibility and enrollment information, please visit www.fepblue.org or call the number on the back of your Service Benefit Plan ID card.

Special features – continued on next page

Hypertension Management Program	The **Hypertension Management Program** gives members with hypertension (otherwise known as high blood pressure), age 18 and older, access to a free blood pressure monitor (BPM) to encourage members to make healthier choices to reduce the potential for complications from cardiac disease. This program is available to any family member 18 and over who meets the criteria whether or not they qualify for the BHA incentive. You will be automatically enrolled in the program, and will be informed of your eligibility to receive a free BPM after the following criteria are met: • You complete the Blue Health Assessment (BHA), and indicate that you have been diagnosed with hypertension. • At least one medical claim has been processed during the past 12 months with a reported diagnosis of hypertension. Once you meet these criteria, CVS Caremark will send you a letter advising you of your eligibility for the free BPM. You are eligible to receive a free BPM every two years. You must follow the directions in the letter, which include taking the letter to your health care provider. Your provider is responsible for documenting your most recent blood pressure reading, and identifying the appropriate BPM size for you. The BPM must be received through this program. Benefits are not available for BPMs for members who do not meet the above criteria or for those who obtain a BPM outside of this program. For more information, call us at the number on the back of your ID card.
Pregnancy Care Incentive Program	The **Pregnancy Care Incentive Program** is designed to encourage early and ongoing prenatal care that improves baby's birth weight and decreased risk of preterm labor. This is a two-step program through which pregnant members can earn a Pregnancy Care Box (with pregnancy gifts and information) and $75 toward a health account to be used for most qualified medical expenses. This incentive is in addition to other incentives described in this brochure. To qualify for the first step in the program, the Pregnancy Care Box, you must be female, age 18 or older, complete the Blue Health Assessment (BHA) questionnaire and enroll in My Pregnancy Assistant, completing all required fields. Information on both programs is available on our website, www.fepblue.org. Also see page 120 for information on the BHA. To qualify for the $75 incentive, you must meet the criteria above for the Pregnancy Care Box (see above) and send us a copy of your health care provider's medical record that confirms you had a prenatal care visit during the first trimester of your pregnancy. The medical record must contain the following information: • Date of prenatal visit • Name and address of the health care provider (e.g., physician, certified nurse midwife, nurse practitioner) providing your prenatal care • Provider's signature • Member's name • Member's date of birth • Member's expected due date or date of last menstrual period ***Note:*** Information on submitting your medical record can be found on our website, www.fepblue.org/maternity. To receive either the Pregnancy Care Box or the $75 incentive reward, members must complete all requirements of the program during the benefit year, and either the first prenatal visit or the delivery must occur during the benefit year. These incentives are offered per pregnancy, and limited to two pregnancies per calendar year.

Special features – continued on next page

MyBlue® Customer eService	Visit **MyBlue® Customer eService** at www.fepblue.org/myblue to check the status of your claims, change your address of record, request claim forms, request a duplicate or replacement Service Benefit Plan ID card, and track how you use your benefits. Additional features include: • **Online EOBs** – You can view, download, and print your explanation of benefits (EOB) forms. Simply log on to MyBlue® Customer eService via www.fepblue.org/myblue and click on "Explanation of Benefits," then "Medical & Pharmacy Claims." From there you can search claims and select the "EOB" link next to each claim to access your EOB. • **Opt Out of Paper EOBs** – The Service Benefit Plan offers an environmentally friendly way of accessing your EOBs. You can opt out of receiving paper EOBs and access your EOBs exclusively online. On the MyBlue homepage, click on "Go Green: Opt out of paper (EOBs)" and follow the on-screen instructions. • **Personalized Messages** – Our EOBs provide a wide range of messages just for you and your family, ranging from preventive care opportunities to enhancements to our online services!
National Doctor & Hospital Finder℠	Visit www.fepblue.org/provider to access our National Doctor & Hospital Finder and other nationwide listings of Preferred providers.
Care Management Programs	If you have a rare or chronic disease or have complex health care needs, the Service Benefit Plan offers two types of Care Management Programs that provide care coordination, member education and clinical support. • **Case Management** provides members who have complex health care needs with the services of a registered nurse certified in case management to assess, coordinate, evaluate, support and monitor the member's treatment plan and health care needs. ***Note:*** Benefits for care provided by residential treatment centers require participation in Case Management; please see page 88 and 100 for additional information. • **Disease Management** supports members who have diabetes, asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease, or congestive heart failure by helping them adopt effective self-care habits to improve the self-management of their condition. If you have been diagnosed with any of these conditions, we may send you information about the programs available to you in your area. If you have any questions regarding these programs, please contact us at the customer service number on the back of your ID card.
Flexible benefits option	Under the Blue Cross and Blue Shield Service Benefit Plan, our Case Management process may include a **flexible benefits option**. This option allows professional case managers at Local Plans to assist members with certain complex and/or chronic health issues by coordinating complicated treatment plans and other types of complex patient care plans. Through the flexible benefits option, case managers may identify a less costly alternative treatment plan for the member. Members who are eligible to receive services through the flexible benefits option are asked to provide verbal consent for the alternative plan. If you and your provider agree with the plan, alternative benefits will begin immediately and you will be asked to sign an **alternative benefits agreement** that includes the terms listed below, in addition to any other terms specified in the agreement. • Alternative benefits will be made available for a limited period of time and are subject to our ongoing review. You must cooperate with the review process. • If we approve alternative benefits, we do not guarantee that they will be extended beyond the limited time period and/or scope of treatment initially approved or that they will be approved in the future. • The decision to offer alternative benefits is solely ours, and unless otherwise specified in the **alternative benefits agreement**, we may withdraw those benefits at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. If you sign the **alternative benefits agreement**, we will provide the agreed-upon benefits for the stated time period, unless we are misled by the information given to us or circumstances change. You may request an extension of the time period initially approved for alternative benefits, but benefits as stated in this brochure will apply if we do not approve your request. Please note that the written **alternative benefits agreement** must be signed by the member or his/her authorized representative and returned to the Plan case manager within 30 days of the date of the alternative benefits agreement. If the Plan does not receive the signed agreement within 30 days, alternative benefits will be withdrawn and benefits as stated in this brochure will apply. ***Note:*** If we deny a request for precertification or prior approval of regular contract benefits, or if we deny regular contract benefits for services you have already received, you may dispute our denial of regular contract benefits under the OPM disputed claims process (see Section 8).

Section 5(i). Services, drugs, and supplies provided overseas

If you travel or live outside the United States, Puerto Rico, and the U.S. Virgin Islands, you are still entitled to the benefits described in this brochure. Unless otherwise noted in this Section, the same definitions, limitations, and exclusions also apply. Costs associated with repatriation from an international location back to the United States are not covered. See Section 10 for a definition of repatriation. See below and pages 124-125 for the claims information we need to process overseas claims. We may request that you provide complete medical records from your provider to support your claim. If you plan to receive health care services in a country sanctioned by the Office of Foreign Assets Control (OFAC) of the U.S. Department of the Treasury, your claim must include documentation of a government exemption under OFAC authorizing care in that country.

Please note that the requirements to obtain precertification for inpatient care and prior approval for those services listed in Section 3 do not apply when you receive care outside the United States.

Overseas claims payment

For **professional care** you receive overseas, we provide benefits at Preferred benefit levels using either our Overseas Fee Schedule or a provider-negotiated discount as our Plan allowance. **The requirement to use Preferred providers in order to receive benefits under Basic Option does not apply when you receive care outside the United States, Puerto Rico, and the U.S. Virgin Islands.**

Under both Standard and Basic Options, when the Plan allowance is based on the Overseas Fee Schedule, you pay any difference between our payment and the amount billed, in addition to any applicable coinsurance and/or copayment amounts. You must also pay any charges for noncovered services (and, under Standard Option only, any applicable deductible amount). **Under both Standard and Basic Options,** when the Plan allowance is a provider-negotiated discount, you are only responsible for your coinsurance and/or copayment amounts and, under Standard Option only, any applicable deductible amount. You must also pay any charges for noncovered services.

For **facility care** you receive overseas, we provide benefits at the Preferred level **under both Standard and Basic Options** after you pay the applicable copayment or coinsurance. Standard Option members are also responsible for any amounts applied to the calendar year deductible for certain outpatient facility services – please see pages 83-86.

For **prescription drugs purchased at overseas pharmacies**, we provide benefits at Preferred benefit levels, using the billed charge as our Plan allowance. Under both Standard and Basic Options, members pay the applicable coinsurance. Standard Option members are not required to meet the calendar year deductible when they purchase drugs at pharmacies located overseas. See page 113 in Section 5(f) for more information.

For **dental care** you receive overseas, we provide benefits as described in Section 5(g). **Under Standard Option,** you must pay any difference between the Schedule of Dental Allowances and the dentist's charge, in addition to any charges for noncovered services. **Under Basic Option,** you must pay the $30 copayment plus any difference between our payment and the dentist's charge, as well as any charges for noncovered services.

For **transport services** you receive overseas, we provide benefits for transport services to the nearest hospital equipped to adequately treat your condition when the transport services are medically necessary. We provide benefits as described in Section 5(c) and Section 5 (d). Benefits are not available for costs associated with transportation to other than the closest hospital equipped to treat your condition. Under **Standard and Basic Options**, members pay the applicable copayment.

Worldwide Assistance Center

We have a network of participating hospitals overseas that will file your claims for inpatient facility care for you – without an advance payment for the covered services you receive. We also have a network of professional providers who have agreed to accept a negotiated amount as payment in full for their services. The Worldwide Assistance Center can help you locate a hospital or physician in our network near where you are staying. You may also view a list of our network providers on our website, www.fepblue.org. You will have to file a claim to us for reimbursement for professional services unless you or your provider contacts the Worldwide Assistance Center in advance to arrange direct billing and payment to the provider.

If you are overseas and need assistance locating providers (whether in or out of our network), contact the Worldwide Assistance Center (provided by AXA Assistance), by calling the center collect at 1-804-673-1678. Members in the United States, Puerto Rico, or the U.S. Virgin Islands should call 1-800-699-4337 or email the Worldwide Assistance Center at fepoverseas@axa-assistance.us. AXA Assistance also offers emergency evacuation services to the nearest facility equipped to adequately treat your condition, translation services, and conversion of foreign medical bills to U.S. currency. You may contact one of their multilingual operators 24 hours a day, 365 days a year.

Filing overseas claims

Most overseas providers are under no obligation to file claims on behalf of our members. Follow the procedures listed below to file claims for covered services and drugs you receive outside the United States, Puerto Rico, and the U.S. Virgin Islands. **You may need to pay for the services at the time you receive them and then send a claim to us for reimbursement.** We will provide translation and currency conversion services for your overseas claims.

- **Hospital and professional provider benefits**

To file a claim for covered hospital and professional provider services received outside the United States, Puerto Rico, and the U.S. Virgin Islands, send us a completed FEP® Overseas Medical Claim Form, by mail, fax, or internet, along with itemized bills from the provider. In completing the claim form, indicate whether you want to be paid in U.S. dollars or in the currency reflected on the itemized bills, and if you want to receive payment by check or bank wire. Use the following information to mail, fax, or submit your claim electronically:

1. Mail: Federal Employee Program®, Overseas Claims, P.O. Box 261570, Miami, FL 33126.
2. Fax: 001-410-781-7637 (or 1-888-650-6525 toll-free). Be sure to first dial the AT&T Direct® Access Code of the country from which you are faxing the claim.
3. Internet: Go to the MyBlue portal on www.fepblue.org. If you are already a registered MyBlue portal user, click on the "Health Tools" menu and, in the "Get Care" section, select "Submit Overseas Claim" and follow the instructions for submitting a medical claim. If you are not yet a registered user, go to MyBlue, click on the 'Sign Up' link, and register to use the online filing process.

If you have questions about your medical claims, call us at 1-888-999-9862, using the AT&T Direct® Access Code of the country from which you are calling, or email us through our website (www.fepblue.org) via the MyBlue portal. You may also write to us at: Mailroom Administrator, FEP® Overseas Claims, P.O. Box 14112, Lexington, KY 40512-4112. You may obtain Overseas Medical Claim Forms from our website, by email at fepoverseas@axa-assistance.us, or from your Local Plan.

- **Pharmacy benefits**

Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription. To file a claim for covered drugs and supplies you purchase from pharmacies outside the United States, Puerto Rico, and the U.S. Virgin Islands, send us a completed FEP® Retail Prescription Drug Overseas Claim Form, along with itemized pharmacy receipts or bills. Use the following information to mail, fax, or submit your claim electronically:

1. Mail: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.
2. Fax: 001-480-614-7674. Be sure to first dial the AT&T Direct® Access Code of the country from which you are faxing the claim.
3. Internet: Go to the MyBlue portal on www.fepblue.org. If you are already a registered MyBlue portal user, click on the "Health Tools" menu and, in the "Get Care" section, select "Submit Overseas Claim" and follow the instructions for submitting a pharmacy claim. If you are not yet a registered user, go to MyBlue, click on the 'Sign Up' link, and register to use the online filing process.

Send any written inquiries concerning drugs you purchase overseas to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057. You may obtain FEP® Retail Prescription Drug Overseas Claim forms for your drug purchases by visiting our website, www.fepblue.org, by writing to the address above, or by calling us at 1-888-999-9862, using the AT&T Direct® Access Code of the country from which you are calling.

While overseas, you may be able to order your prescription drugs through the Mail Service Prescription Drug Program or our Specialty Drug Pharmacy Program as long as all of the following conditions are met:

- Your address includes a U.S. ZIP code (such as with APO and FPO addresses and in U.S. territories),
- The prescribing physician is licensed in the United States, Puerto Rico, or the U.S. Virgin Islands, and has a National Provider Identifier (NPI), and
- Delivery of the prescription is permitted by law and is in accordance with the manufacturer's guidelines.

See Section 5(f) for more information about Preferred retail pharmacies with online ordering options, the Mail Service Prescription Drug Program, and the Specialty Drug Pharmacy Program.

The Mail Service Prescription Drug Program is available to Standard Option members and to Basic Option members with primary Medicare Part B coverage.

Note: In most cases, temperature-sensitive drugs cannot be sent to APO/FPO addresses due to the special handling they require.

Note: We are unable to ship drugs, through either our Mail Service Prescription Drug Program or our Specialty Drug Pharmacy Program, to overseas countries that have laws restricting the importation of prescription drugs from any other country. This is the case even when a valid APO or FPO address is available. If you are living in such a country, you may obtain your prescription drugs from a local overseas pharmacy and submit a claim to us for reimbursement by faxing it to 001-480-614-7674 or filing it via our website at www.fepblue.org/myblue.

Non-FEHB benefits available to Plan members

The benefits on these pages are not part of the FEHB contract or premium, **and you cannot file an FEHB dispute regarding these benefits**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. In addition, these services are not eligible for benefits under the FEHB Program. Please do not file a claim for these services. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information, contact us at the phone number on the back of your ID card or visit our website at www.fepblue.org.

Blue365®

Living a healthy life is all about making good choices every day, so what if your health insurer could help you do just that? The Service Benefit Plan presents Blue365®, an exciting program that offers exclusive health and wellness deals that will keep you healthy and happy, every day of the year.

Blue365 delivers members great discounts from top national and local retailers on healthy living resources such as:

- Hearing Aids
- LASIK Vision Correction
- Diet and Weight Management Programs
- Fitness Gear and Much More

You know what it takes to keep your mind and body happy and healthy, and Blue365 has the deals to help you every step of the way.

Staying healthy shouldn't be difficult. Each week, Blue365 members receive great health and wellness deals straight to their inbox, so they can save with just one click. With Blue365, there is no paperwork to fill out. All you have to do is visit www.fepblue.org/blue365. Select *Get Started* and then log in to MyBlue® with your Username and Password to learn more about the various Blue365 vendors and discounts.

The Blue Cross and Blue Shield Service Benefit Plan may receive payments from Blue365 vendors. The Plan does not recommend, endorse, warrant, or guarantee any specific Blue365 vendor or item. Vendors and the program are subject to change at any time.

Health Club Memberships

The Opportunity

The first fitness plan with flexibility to meet your life's needs.

Whether your goals are physical, such as losing weight and maximizing energy, or emotional, like dealing with stress and improving your mood, Healthways™ Fitness Your Way can help you meet your goals, on your budget, and do it all on your own time. Healthways Fitness Your Way offers access to more than 9,000 different fitness locations for just $25 a month.

The Details

Fitness for your budget

- Only $25 per month and a low $25 enrollment fee, with a 3-month commitment*

Fitness for your time

- Visit any participating fitness location – anytime, anywhere – as often as you like
- Locations include but are not limited to select Anytime Fitness®, Curves®, and Planet Fitness®. A limited number of Gold's Gyms and YMCAs in certain areas are also participating.
- Access well-being support, health articles, and online health coaching, 24 hours a day, 7 days a week

Flexibility to achieve your goals

- With over 9,000 locations, find fitness classes that fit you and your needs
- Easy online tools to track exercise and nutrition goals
- Stay motivated with social networking, rewards, and the Daily Challenge

For more information or to enroll, go to www.fepblue.org/healthclub or call customer service at 1-888-242-2060, Monday through Friday,
8 a.m. – 9 p.m., in all U.S. time zones.

**Taxes may apply. Individuals must be 18 or older to purchase a membership.*

Discount Drug Program

The Discount Drug Program is available to Service Benefit Plan enrollees at no additional premium cost. It enables you to purchase, at discounted prices, certain prescription drugs that are not covered by the regular prescription drug benefit. Discounts vary by drug product, but average about 20%. The program permits you to obtain discounts on the following drugs:

For dental care: Peridex;

For sexual/erectile dysfunction: Caverject injection, Cialis tablet, Edex injection, Levitra tablet, Muse suppository, Staxyn tablet, Stendra tablet, Viagra tablet, and Yohimbine;

For weight loss: Adipex-P, Belviq, Benzphetamine, Bontril PDM, Contrave, Didrex, Diethylpropion, Meridia capsule, Phendimetrazine, Phentermine, Pro-Fast SR, Qsymia, Saxenda, Suprenza ODT, and Xenical capsule;

For hair removal: Vaniqa cream;

For hair growth: Propecia;

For skin pigmenting/depigmenting/re-pigmenting: Retinoids [Renova 0.02% (tretinoin) and Avage 0.1% (tazarotene)], Hydroquinone-containing products (Aclaro, Eldoquin Forte, Epiquin Micro, Lustra, Melanex, Melpaque, Nuquin, Obagi Products, Remergent, Solaquin Forte, and Tri-Luma), Monobenzone products (Benoquin), and Tretinoin 0.02%; and

For Miscellaneous: Kybella, Latisse and Varithena.

Drugs may be added to this list as they are approved by the U.S. Food and Drug Administration (FDA). To use the program, simply present a valid prescription and your Service Benefit Plan ID card at a network retail pharmacy. The pharmacist will ask you for payment in full at the negotiated discount rate. For more information, visit www.fepblue.org/ddp or call 1-800-624-5060.

Vision Care Affinity Program

Service Benefit Plan members can receive routine eye exams, frames, lenses, and conventional contact lenses at substantial savings when using Davis Vision network providers. Members can also save up to 25% off the provider's usual fee, or 5% off sales pricing, on laser vision correction procedures. There are over 48,000 points of access including optometrists, ophthalmologists, and many retailers. For a complete description of the program or to find a provider near you, go to www.fepblue.org/vcap. You may also call us at 1-800-551-3337 between 8:00 a.m. and 11:00 p.m. Eastern Time, Monday to Friday;
9:00 a.m. to 4:00 p.m. on Saturday; or noon to 4:00 p.m. on Sunday. Please be sure to verify that the provider participates in our Vision Care Affinity Program and ask about the discounts available before your visit, as discounts may vary.

ARAG® Legal Center

Members have access to **The Education Center™** which offers a collection of legal tools and resources that provide helpful tips and simple explanations for complex legal terms and scenarios, as well as guidance on where to turn for more information and assistance. The center includes a secure Personal Information Organizer, Guidebooks and videos, the Law Guide, and an e-newsletter. To access this free service, visit www.fepblue.org/arag, or contact the ARAG Customer Care Center at 1-800-255-9509. Please reference FEP or 17823 when contacting the ARAG Customer Care Center.

DIY Docs™

Members also have the opportunity to purchase a **Do-It-Yourself Documents (DIY Docs)** package for a low annual subscription rate of $69.95 (30% off the $99 retail rate). DIY Docs members receive online access to over 350 interactive, state-specific legal documents that can be customized by the member. These documents are authored and reviewed by attorneys for accuracy and to ensure they are legally valid in all 50 states. Available DIY Docs include a Will, Living Will, Powers of Attorney, Medical Authorization for a Minor, Bill of Sale, Contract, Residential Lease, and much more.

The DIY Docs package includes an easy-to-use document assembly tool that enables members to create, update, store, and print documents at any time. For more information or to purchase DIY Docs, visit www.fepblue.org/arag and click *Get Started*, or contact the ARAG Customer Care Center at 1-800-255-9509. Please reference FEP or 17823 when contacting the ARAG Customer Care Center.

Section 6. General exclusions – services, drugs, and supplies we do not cover

The exclusions in this Section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.** For information on obtaining prior approval for specific services, such as transplants, see Section 3 (*You need prior Plan approval for certain services*).

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States.
- Services, drugs, or supplies billed by Preferred and Member facilities for inpatient care related to specific medical errors and hospital-acquired conditions known as Never Events (see definition on page 147).
- Experimental or investigational procedures, treatments, drugs, or devices (see specifics regarding transplants).
- Services, drugs, or 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.
- Services, drugs, or supplies related to sexual dysfunction or sexual inadequacy (except for surgical placement of penile prostheses to treat erectile dysfunction).
- Services, drugs, or supplies you receive from a provider or facility barred or suspended from the FEHB Program.
- Services, drugs, or supplies you receive in a country sanctioned by the Office of Foreign Assets Control (OFAC) of the U.S. Department of the Treasury, from a provider or facility not appropriately licensed to deliver care in that country.
- Services or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services, drugs, or supplies you receive without charge while in active military service.
- Charges which 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 142), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 143), or state premium taxes however applied.
- Services or supplies ordered, performed, or furnished by you or your immediate relatives or household members, such as spouse, parents, children, brothers, or sisters by blood, marriage, or adoption.
- Services or supplies furnished or billed by a noncovered facility, except that medically necessary prescription drugs; oxygen; and physical, speech, and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits.
- Services, drugs, or supplies you receive from noncovered providers.
- Services, drugs, or supplies you receive for cosmetic purposes.
- Services, drugs, or supplies for the treatment of obesity, weight reduction, or dietary control, except for office visits and diagnostic tests for the treatment of obesity; gastric restrictive procedures, gastric malabsorptive procedures, and combination restrictive and malabsorptive procedures for the treatment of morbid obesity (see pages 66 and 67); and those nutritional counseling services specifically listed on pages 39, 43, 47, and 81.
- Services you receive from a provider that are outside the scope of the provider's licensure or certification.
- Any dental or oral surgical procedures or drugs involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for the fitting or continued use of dentures, except as specifically described in Section 5(g), *Dental benefits,* and Section 5(b) under *Oral and maxillofacial surgery*.
- Orthodontic care for malposition of the bones of the jaw or for temporomandibular joint (TMJ) syndrome.
- Services of standby physicians.
- Self-care or self-help training.
- Custodial or long term care (see *Definitions*).
- Personal comfort items such as beauty and barber services, radio, television, or telephone.
- Furniture (other than medically necessary durable medical equipment) such as commercial beds, mattresses, chairs.

- Routine services, such as periodic physical examinations; screening examinations; immunizations; and services or tests not related to a specific diagnosis, illness, injury, set of symptoms, or maternity care, except for those preventive services specifically covered under Preventive care, adult and child in Sections 5(a) and 5(c), the preventive screenings specifically listed on pages 42-47 and page 86; and certain routine services associated with covered clinical trials (see page 137).
- Recreational or educational therapy, and any related diagnostic testing, except as provided by a hospital during a covered inpatient stay.
- Applied behavior analysis (ABA) or ABA therapy.
- Topical Hyperbaric Oxygen Therapy (THBO).
- Research costs (costs related to conducting a clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes).
- Professional charges for after-hours care, except when associated with services provided in a physician's office.
- Incontinence products such as incontinence garments (including adult or infant diapers, briefs, and underwear), incontinence pads/liners, bed pads, or disposable washcloths.
- Alternative medicine services including, but not limited to, botanical medicine, aromatherapy, herbal/nutritional supplements (see page 114), meditation techniques, relaxation techniques, movement therapies, and energy therapies.
- Services not specifically listed as covered.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs, or supplies you have already received).

See Section 3 for information on pre-service claims procedures (services, drugs, or supplies requiring precertification or prior approval), including urgent care claims procedures.

How to claim benefits

To obtain claim forms or other claims filing advice, or answers to your questions about our benefits, contact us at the customer service number on the back of your Service Benefit Plan ID card, or at our website at www.fepblue.org.

In most cases, physicians and facilities file claims for you. Just present your Service Benefit Plan ID card when you receive services. Your physician must file on the CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form.

When you must file a claim – such as when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Use a separate claim form for each family member. For long or continuing inpatient stays, or other long-term care, you should submit claims at least every 30 days. Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number, and relationship to enrollee
- Patient's Plan identification number
- Name and address of person or company providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply
- Charge for each service or supply

Note: Canceled checks, cash register receipts, balance due statements, or bills you prepare yourself are not acceptable substitutes for itemized bills.

In addition:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor [such as the Medicare Summary Notice (MSN)] with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- If your claim is for the rental or purchase of durable medical equipment, home nursing care, or physical, occupational, or speech therapy, you must provide a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for dental care to repair accidental injury to sound natural teeth should include documentation of the condition of your teeth before the accidental injury, documentation of the injury from your provider(s), and a treatment plan for your dental care. We may request updated treatment plans as your treatment progresses.
- Claims for prescription drugs and supplies that are not received from the Retail Pharmacy Program, through the Mail Service Prescription Drug Program, or through the Specialty Drug Pharmacy Program must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, and charge. (See pages 131-132 for information on how to obtain benefits from the Retail Pharmacy Program, the Mail Service Prescription Drug Program, and the Specialty Drug Pharmacy Program.)

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Prescription drug claims

Preferred Retail Pharmacies – When you use Preferred retail pharmacies, show your Service Benefit Plan ID card. To find a Preferred pharmacy, visit www.fepblue.org/provider. If you use a Preferred retail pharmacy that offers online ordering, have your ID card ready to complete your purchase. Preferred retail pharmacies file your claims for you. We reimburse them for your covered drugs and supplies. You pay the applicable coinsurance or copayment.

Note: Even if you use Preferred pharmacies, you will have to file a paper claim form to obtain reimbursement if:

- You do not have a valid Service Benefit Plan ID card;
- You do not use your valid Service Benefit Plan ID card at the time of purchase; or
- You did not obtain prior approval when required (see page 24).

See the following paragraph for claim filing instructions.

Non-Preferred Retail Pharmacies

Standard Option: You must file a paper claim for any covered drugs or supplies you purchase at Non-preferred retail pharmacies. Contact your Local Plan or call 1-800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired members with TDD equipment may call 1-800-624-5077. Follow the instructions on the prescription drug claim form and submit the completed form to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.

Basic Option: There are **no benefits** for drugs or supplies purchased at Non-preferred retail pharmacies.

Mail Service Prescription Drug Program

Eligible members: We will send you information on our Mail Service Prescription Drug Program, including an initial mail order form. To use this program:

1. Complete the initial mail order form;
2. Enclose your prescription and copayment;
3. Mail your order to CVS Caremark, P.O. Box 1590, Pittsburgh, PA 15230-1590; and
4. Allow up to two weeks for delivery.

Alternatively, your physician may call in your initial prescription at 1-800-262-7890 (TDD: 1-800-216-5343). You are responsible for the copayment. You are also responsible for the copayments for refills ordered by your physician.

After that, to order refills either call the same number or access our website at www.fepblue.org and either charge your copayment to your credit card or have it billed to you later. Allow up to ten days for delivery on refills.

Note: Specialty drugs will not be dispensed through the Mail Service Prescription Drug Program. See page 132 for information about the Specialty Drug Pharmacy Program.

Basic Option: The Mail Service Prescription Drug Program is available only to members with primary Medicare Part B coverage under Basic Option.

Specialty Drug Pharmacy Program

Standard and Basic Options: If your physician prescribes a specialty drug that appears on our Service Benefit Plan Specialty Drug List, your physician may order the initial prescription by calling our Specialty Drug Pharmacy Program at 1-888-346-3731 (TDD: 1-877-853-9549), or you may send your prescription to: Specialty Drug Pharmacy Program, CVS Caremark, P.O. Box 1590, Pittsburgh, PA 15230-1590. You will be billed later for the copayment. The Specialty Drug Pharmacy Program will work with you to arrange a delivery time and location that is most convenient for you. To order refills, call the same number to arrange your delivery. You may either charge your copayment to your credit card or have it billed to you later.

Note: For the most up-to-date listing of covered specialty drugs, call the Specialty Drug Pharmacy Program at 1-888-346-3731 (TDD: 1-877-853-9549), or visit our website, www.fepblue.org.

Records

Keep a separate record of the medical expenses of each covered family member, because deductibles (under Standard Option) and benefit maximums (such as those for outpatient physical therapy or preventive dental care) apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible under Standard Option. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us your claim and appropriate documentation as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided you submitted the claim as soon as reasonably possible. If we return a claim or part of a claim for additional information, you must resubmit it within 90 days, or before the timely filing period expires, whichever is later.

Note: Once we pay benefits, there is a five-year limitation on the re-issuance of uncashed checks.

Overseas claims

Please refer to the claims filing information on pages 124-125 of this brochure.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this Section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

The Secretary of Health and Human Services has identified counties where at least 10 percent of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo, and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your explanation of benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the procedure or treatment code and its corresponding meaning.

Section 8. The disputed claims process

Please follow this Federal Employees Health Benefits Program disputed claims process **if you disagree with our decision on your post-service claim** (a claim where services, drugs, or supplies have already been provided). In Section 3, ***If you disagree with our pre-service claim decision***, we describe the process you need to follow if you have a claim for services, drugs, or supplies that must have precertification (such as inpatient hospital admissions) or prior approval from the Plan.

You may appeal directly to the U.S. Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7, and 8 of this brochure, please visit www.fepblue.org.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please call us at the customer service number on the back of your Service Benefit Plan ID card, or send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program, Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program, Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program); and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in Step 3.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

The disputed claims process *(continued)*

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information – if we did not send you a decision within 30 days after we received the additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 1, 1900 E Street NW, Washington, DC 20415-3610.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to file a lawsuit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies, or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claims decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at the customer service number on the back of your Service Benefit Plan ID card. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 1 at (202) 606-0727 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this Plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant, or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other group health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For example:

- If you are covered under our Plan as a dependent, any group health insurance you have from your employer will pay primary and we will pay secondary.
- If you are an annuitant under our Plan and also are actively employed, any group health insurance you have from your employer will pay primary and we will pay secondary.
- When you are entitled to the payment of health care expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payor and we are the secondary payor.

For more information, visit the NAIC website at www.NAIC.org.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. For example, we will generally only make up the difference between the primary payor's benefits payment and 100% of the Plan allowance, subject to our applicable deductible (under Standard Option) and coinsurance or copayment amounts, except when Medicare is the primary payor (see page 143). Thus, it is possible that the combined payments from both plans may not equal the entire amount billed by the provider.

Note: When we pay secondary to primary coverage you have from a prepaid plan (HMO), we base our benefits on your out-of-pocket liability under the prepaid plan (generally, the prepaid plan's copayments), subject to our deductible (under Standard Option) and coinsurance or copayment amounts.

In certain circumstances when we are secondary and there is no adverse effect on you (that is, you do not pay any more), we may also take advantage of any provider discount arrangements your primary plan may have and only make up the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan.

Note: Any visit limitations that apply to your care under this Plan are still in effect when we are the secondary payor.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage, and you must also send us documents about your other coverage if we ask for them.

Please see Section 4, *Your costs for covered services*, for more information about how we pay claims.

• TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we paid benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if we paid benefits for that injury, you must agree to the following provisions:

- All recoveries you or your representatives obtain (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you, your representatives, and/or health care providers on your behalf. For purposes of this provision, "you" includes your covered dependents, and "your representatives" include, if applicable, your heirs, administrators, legal representatives, parents (if you are a minor), successors, or assignees. This is our right of recovery.
- We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. Our right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.
- We will not reduce our share of any recovery unless, in the exercise of our discretion, we agree in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.
- You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must not take any action that may prejudice our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.

If you do seek damages for your illness or injury, you must tell us promptly that you have made a claim against another party for a condition that we have paid or may pay benefits for, you must seek recovery of our benefit payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a first priority lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you sign a reimbursement agreement and/or assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the signed reimbursement agreement and/or assignment, and we may enforce our right of recovery by offsetting future benefits.

Note: We will pay the costs of any covered services you receive that are in excess of any recoveries made.

Our rights of recovery and subrogation as described in this Section may be enforced, at the Carrier's option, by the Carrier, by any of the Local Plans that administered the benefits paid in connection with the injury or illness at issue, or by any combination of these entities. Please be aware that more than one Local Plan may have a right of recovery/subrogation for claims arising from a single incident (e.g., a car accident resulting in claims paid by multiple Local Plans) and that the resolution by one Local Plan of its lien will not eliminate another Local Plan's right of recovery.

Among the other situations covered by this provision, the circumstances in which we may subrogate or assert a right of recovery shall also include:

- When a third party injures you, for example, in an automobile accident or through medical malpractice;
- When you are injured on premises owned by a third party; or
- When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:
  - No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by you to treat those benefits as secondary to this Plan
  - Uninsured and underinsured motorist coverage
  - Workers' Compensation benefits
  - Medical reimbursement coverage

Contact us if you need more information about subrogation.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)

Some FEHB plans already cover some dental and vision services. When you are covered by more than one dental/vision plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

If you are a participant in an approved clinical trial, this health Plan will provide benefits for related care as follows, if it is not provided by the clinical trial:

- **Routine care costs** – costs for medically necessary services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. We provide benefits for these types of costs at the benefit levels described in Section 5 (*Benefits*) when the services are covered under the Plan and we determine that they are medically necessary.

- **Extra care costs** – costs of covered services related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan covers extra care costs related to taking part in an approved clinical trial for a covered stem cell transplant such as additional tests that a patient may need as part of the clinical trial protocol, but not as part of the patient's routine care. For more information about approved clinical trials for covered stem cell transplants, see pages 74-75. Extra care costs related to taking part in any other type of clinical trial are not covered. We encourage you to contact us at the customer service number on the back of your ID card to discuss specific services if you participate in a clinical trial.

- **Research costs** – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048), for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on page 140.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure.

  For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213, (TTY: 1-800-325-0778).

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, (TTY: 1-800-325-0778), to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you do not have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

(Please refer to page 142 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. For example, you must continue to obtain prior approval for some prescription drugs and organ/tissue transplants before we will pay benefits. However, you do not have to precertify inpatient hospital stays when Medicare Part A is primary (see page 22 for exception).

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When the Original Medicare Plan is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for the covered charges. To find out if you need to do something to file your claims, call us at the customer service number on the back of your Service Benefit Plan ID card or visit our website at www.fepblue.org.

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

When Medicare Part A is primary –

- Under **Standard Option**, we will waive our:
  - Inpatient hospital per-admission copayments; and
  - Inpatient Member and Non-member hospital coinsurance.
- Under **Basic Option**, we will waive our:
  - Inpatient hospital per-day copayments.

Note: Once you have exhausted your Medicare Part A benefits:

- Under **Standard Option**, you must then pay any difference between our allowance and the billed amount at Non-member hospitals.
- Under **Basic Option**, you must then pay the inpatient hospital per-day copayments.

When Medicare Part B is primary –

- Under **Standard Option**, we will waive our:
  - Calendar year deductible;
  - Coinsurance and copayments for inpatient and outpatient services and supplies provided by physicians and other covered health care professionals; and
  - Coinsurance for outpatient facility services.
- Under **Basic Option**, we will waive our:
  - Copayments and coinsurance for care received from covered professional and facility providers.

Note: We do not waive benefit limitations, such as the 25-visit limit for home nursing visits. In addition, we do not waive any coinsurance or copayments for prescription drugs.

You can find more information about how our Plan coordinates benefits with Medicare in our *Medicare and You Guide for Federal Employees* available online at www.fepblue.org.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Private contract with your physician**

A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. You may be responsible for paying the difference between the billed amount and the amount we paid.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048), or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB Plan. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Under Standard Option, we will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area. However, we will not waive any of our copayments, coinsurance, or deductibles, if you receive services from providers who do not participate in the Medicare Advantage plan.

Under Basic Option, we provide benefits for care received from Preferred providers when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area. However, we will not waive any of our copayments or coinsurance for services you receive from Preferred providers who do not participate in the Medicare Advantage plan. Please remember that you must receive care from Preferred providers in order to receive Basic Option benefits. See page 21 for the exceptions to this requirement.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

- **Medicare prescription drug coverage (Part B)**

This health plan **does not** coordinate its prescription drug benefits with Medicare Part B.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you – or your covered spouse – are age 65 or over and have Medicare and you . . .	**The primary payor for the individual with Medicare is . . .**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and . . .		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member . . .		
1) Have Medicare solely based on end stage renal disease (ESRD) and . . .		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and . . .		
• This Plan was the primary payor before eligibility due to ESRD (for the 30-month coordination period)		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and . . .		
• Medicare based on age and disability	✓	
• Medicare based on ESRD (for the 30-month coordination period)		✓
• Medicare based on ESRD (after the 30-month coordination period)	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you . . .		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

* Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

When you are age 65 or over and do not have Medicare

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital care and non-physician based care are not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you:

- are age 65 or over; and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, **or** as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care:

- The law requires us to base our payment on an amount – the "equivalent Medicare amount" – set by Medicare's rules for what Medicare would pay, not on the actual charge.
- You are responsible for your deductible (Standard Option only), coinsurance, or copayments under this Plan.
- You are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you.
- The law prohibits a hospital from collecting more than the equivalent Medicare amount.

And, for your physician care, the law requires us to base our payment and your applicable coinsurance or copayment on:

- an amount set by Medicare and called the "Medicare approved amount," or
- the actual charge if it is lower than the Medicare approved amount.

If your physician:	**Then you are responsible for:**	
Participates with Medicare or accepts Medicare assignment for the claim and is in our Preferred network	Standard Option:	your deductibles, coinsurance, and copayments.
	Basic Option:	your copayments and coinsurance.
Participates with Medicare or accepts Medicare assignment and is **not** in our Preferred network	Standard Option:	your deductibles, coinsurance, and copayments, and any balance up to the Medicare approved amount.
	Basic Option:	all charges.
Does not participate with Medicare, and is in our Preferred network	Standard Option:	your deductibles, coinsurance, and copayments, and any balance up to 115% of the Medicare approved amount.
	Basic Option:	your copayments and coinsurance, and any balance up to 115% of the Medicare approved amount.
		Note: In many cases, your payment will be less because of our Preferred agreements. Contact your Local Plan for information about what your specific Preferred provider can collect from you.
Does not participate with Medicare and is **not** in our Preferred network	Standard Option:	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.
	Basic Option:	all charges.

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

When you have the Original Medicare Plan (Part A, Part B, or both)

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays.

Note: We pay our regular benefits for emergency services to a facility provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the MRA statement is submitted to determine our payment for covered services provided to you if Medicare is primary, when Medicare does not pay the VA facility.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

- If your physician **accepts** Medicare assignment, then you pay nothing for covered charges (see note below for Basic Option).
- If your physician **does not accept** Medicare assignment, then you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment (see note below for Basic Option).

Note: **Under Basic Option,** you must see **Preferred** providers in order to receive benefits. See page 21 for the exceptions to this requirement.

It is important to know that a physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) form that you receive from Medicare will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

Section 10. Definitions of terms we use in this brochure

Accidental injury

An injury caused by an external force or element such as a blow or fall that requires immediate medical attention, including animal bites and poisonings. ***Note:*** Injuries to the teeth while eating are **not** considered accidental injuries. Dental care for accidental injury is limited to dental treatment necessary to repair sound natural teeth.

Admission

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

Agents

Medicines and other substances or products given by mouth, inhaled, placed on you, or injected in you to diagnose, evaluate, and/or treat your condition. Agents include medicines and other substances or products necessary to perform tests such as bone scans, cardiac stress tests, CT Scans, MRIs, PET Scans, lung scans, and X-rays, as well as those injected into the joint.

Assignment

An authorization by the enrollee or spouse for us to issue payment of benefits directly to the provider. We reserve the right to pay you, the enrollee, directly for all covered services.

Assisted reproductive technology (ART)

Reproductive services, testing, and treatments involving manipulation of eggs, sperm, and embryos to achieve pregnancy. In general, assisted reproductive technology (ART) procedures are used to retrieve eggs from a woman, combine them with sperm in the laboratory, and then implant the embryos or donate them to another woman.

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.

Carrier

The Blue Cross and Blue Shield Association, on behalf of the local Blue Cross and Blue Shield Plans.

Case management

A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's health needs through communication and available resources to promote quality, cost-effective outcomes (Case Management Society of America, 2012). Each Blue Cross and Blue Shield Plan administers a case management program to assist Service Benefit Plan members with certain complex and/or chronic health issues. Each program is staffed by licensed health care professionals (Case Managers) and some Case Management programs are independently accredited. For additional information regarding case management, call us at the telephone number listed on the back of your Service Benefit Plan ID card.

Clinical trials cost categories

If you are a participant in an approved clinical trial, this health Plan will provide benefits for related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for medically necessary services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 28.

Concurrent care claims

A claim for continuing care or an ongoing course of treatment that is subject to prior approval. See pages 25 and 26 in Section 3.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 27.

Cosmetic surgery

Any surgical procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form, except for repair of accidental injury, or to restore or correct a part of the body that has been altered as a result of disease or surgery or to correct a congenital anomaly.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services

Services we provide benefits for, as described in this brochure.

Custodial or long term care

Facility-based care that does not require access to the full spectrum of services performed by licensed health care professionals that is available 24 hours-a-day in acute inpatient hospital settings to avoid imminent, serious, medical or psychiatric consequences. By "facility-based," we mean services provided in a hospital, long term care facility, extended care facility, skilled nursing facility, residential treatment center, school, halfway house, group home, or any other facility providing skilled or unskilled treatment or services to individuals whose conditions have been stabilized. Custodial or long term care can also be provided in the patient's home, however defined.

Custodial or long term care may include services that a person not medically skilled could perform safely and reasonably with minimal training, or that mainly assist the patient with daily living activities, such as:

1. Personal care, including help in walking, getting in and out of bed, bathing, eating (by spoon, tube, or gastrostomy), exercising, or 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 can perform with minimal instruction, such as recording pulse, temperature, and respiration; or administration and monitoring of feeding systems.

We do not provide benefits for custodial or long term care, regardless of who recommends the care or where it is provided. The Carrier, its medical staff, and/or an independent medical review determine which services are custodial or long term care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies in a calendar year before we start paying benefits for those services. See page 27.

Diagnostic service

An examination or test of an individual with signs, symptoms, or a probability of having a specific disease to determine the presence of that disease; or an examination or test to evaluate the course of treatment for a specific disease.

Durable medical equipment

Equipment and supplies that:

1. Are prescribed by your physician (i.e., the physician who is treating your illness or injury);
2. Are medically necessary;
3. Are primarily and customarily used only for a medical purpose;
4. Are generally useful only to a person with an illness or injury;
5. Are designed for prolonged use; and
6. Serve a specific therapeutic purpose in the treatment of an illness or injury.

Experimental or investigational services

Experimental or investigational shall mean:

a. A drug, device, or biological product that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA); and approval for marketing has not been given at the time it is furnished; or

b. Reliable evidence shows that the health care service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) 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

c. Reliable evidence shows that the consensus of opinion among experts regarding the health care service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) 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; or

d. Reliable evidence shows that the health care service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) does not improve net health outcome, is not as beneficial as any established alternatives, or does not produce improvement outside of the research setting.

Reliable evidence shall mean only evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and physician specialty society recommendations, such as:

a. Published reports and articles in the authoritative medical and scientific literature;

b. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or

c. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or biological product or medical treatment or procedure.

Generic alternative

A generic alternative is an FDA-approved generic drug in the same class or group of drugs as your brand-name drug. The therapeutic effect and safety profile of a generic alternative are similar to your brand-name drug, but it has a different active ingredient.

Generic equivalent

A generic equivalent is a drug whose active ingredients are identical in chemical composition to those of its brand-name counterpart. Inactive ingredients may not be the same. A generic drug is considered "equivalent," if it has been approved by the FDA as interchangeable with your brand-name drug.

Group health coverage

Health care coverage that you are eligible for based on your employment, or your membership in or connection with a particular organization or group, that provides payment for medical services or supplies, or that pays a specific amount of more than $200 per day for hospitalization (including extension of any of these benefits through COBRA).

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law. See pages 18-19 for information about how we determine which health care professionals are covered under this Plan.

Health Risk Assessment (HRA)

A questionnaire designed to assess your overall health and identify potential health risks. Service Benefit Plan members have access to the Blue Cross and Blue Shield HRA (called the "Blue Health Assessment") which is supported by a computerized program that analyzes your health and lifestyle information and provides you with a personal and confidential health action plan that is protected by HIPAA privacy and security provisions. Results from the Blue Health Assessment include practical suggestions for making healthy changes and important health information you may want to discuss with your health care provider. For more information, visit our website, www.fepblue.org.

Intensive outpatient care

A comprehensive, structured outpatient treatment program that includes extended periods of individual or group therapy sessions designed to assist members with mental health and/or substance abuse conditions. It is an intermediate setting between traditional outpatient therapy and partial hospitalization, typically performed in an outpatient facility or outpatient professional office setting. Program sessions may occur more than one day per week. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Local Plan

A Blue Cross and/or Blue Shield Plan that serves a specific geographic area.

Medical foods

The term medical food, as defined in Section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." In general, to be considered a medical food, a product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the product must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and the product must be intended to be used under medical supervision.

Medical necessity

All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine that the criteria for medical necessity are met. Medical necessity shall mean health care services that a physician, hospital, or other covered professional or facility provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

a. In accordance with generally accepted standards of medical practice in the United States; and

b. Clinically appropriate, in terms of type, frequency, extent, site, and duration; and considered effective for the patient's illness, injury, disease, or its symptoms; and

c. Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury, or disease, or its symptoms; and

d. Not part of or associated with scholastic education or vocational training of the patient; and

e. In the case of inpatient care, only provided safely in the acute inpatient hospital setting.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and physician specialty society recommendations.

The fact that one of our covered physicians, hospitals, or other professional or facility providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.

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; or disorders listed in the ICD requiring treatment for abuse of, or dependence upon, substances such as alcohol, narcotics, or hallucinogens.

Never Events

Errors in medical care that are clearly identifiable, preventable, and serious in their consequences, such as surgery performed on a wrong body part, and specific conditions that are acquired during your hospital stay, such as severe bed sores.

Observation services

Although you may stay overnight in a hospital room and receive meals and other hospital services, some services and overnight stays – including "**observation services**" – are actually outpatient care. Observation care includes care provided to members who require significant treatment or monitoring before a physician can decide whether to admit them on an inpatient basis, or discharge them to home. The provider may need 6 to 24 hours or more to make that decision.

If you are in the hospital more than a few hours, always ask your physician or the hospital staff if your stay is considered inpatient or outpatient.

Partial hospitalization

An intensive facility-based treatment program during which an interdisciplinary team provides care related to mental health and/or substance abuse conditions. Program sessions may occur more than one day per week and may be full or half days, evenings, and/or weekends. The duration of care per session is less than 24 hours. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your cost-share for covered services. Fee-for-service plans determine their allowances in different ways. If the amount your provider bills for covered services is less than our allowance, we base your share (coinsurance, deductible, and/or copayments), on the billed amount. We determine our allowance as follows:

- **PPO providers –** Our allowance (which we may refer to as the "PPA" for "Preferred Provider Allowance") is the negotiated amount that Preferred providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with each local Blue Cross and Blue Shield Plan, and retail pharmacies that contract with CVS Caremark) have agreed to accept as payment in full, when we pay primary benefits.

  Our PPO allowance includes any known discounts that can be accurately calculated at the time your claim is processed. For PPO facilities, we sometimes refer to our allowance as the "Preferred rate." The Preferred rate may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost-sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf. (See page 116 for special information about limits on the amounts Preferred dentists can charge you under Standard Option.)

- **Participating providers –** Our allowance (which we may refer to as the "PAR" for "Participating Provider Allowance") is the negotiated amount that these providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with some local Blue Cross and Blue Shield Plans) have agreed to accept as payment in full, when we pay primary benefits. For facilities, we sometimes refer to our allowance as the "Member rate." The member rate includes any known discounts that can be accurately calculated at the time your claim is processed, and may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost-sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf.

- **Non-participating providers –** We have no agreements with these providers to limit what they can bill you for their services. **This means that using Non-participating providers could result in your having to pay significantly greater amounts for the services you receive.** We determine our allowance as follows:

  – For inpatient services at hospitals, and other facilities that do not contract with your local Blue Cross and Blue Shield Plan ("Non-member facilities"), our allowance is based on the average amount paid nationally on a per day basis to contracting and non-contracting facilities for covered room, board, and ancillary charges for your type of admission. If you would like additional information, or to obtain the current allowed amount, please call the customer service number on the back of your ID card. For inpatient stays resulting from medical emergencies or accidental injuries, or for routine deliveries, our allowance is the billed amount;

- For outpatient, non-emergency surgical services at hospitals and other facilities that do not contract with your local Blue Cross and Blue Shield Plan ("Non-member facilities"), our allowance is the average amount for all outpatient surgical claims combined that we pay nationally to contracting and non-contracting facilities. This allowance applies to all of the covered surgical services billed by the hospital and is the same regardless of the type of surgery performed. If you plan on using a Non-member hospital, or other Non-member facility, for your outpatient surgical procedure, please call us before your surgery at the customer service number on the back of your ID card to obtain the current allowed amount and assistance in estimating your total out-of-pocket expenses.
- For outpatient dialysis services performed or billed by hospitals and other facilities that do not contract with the local Blue Cross and Blue Shield Plan ("Non-member facilities"), our allowance is the Local Plan allowance in the geographic area in which the care was performed or obtained. This allowance applies to the covered dialysis services billed by the hospital or facility. Contact your Local Plan if you need more information.

  Please keep in mind that Non-member facilities may bill you for any difference between the allowance and the billed amount. You may be able to reduce your out-of-pocket expenses by using a Preferred hospital for your outpatient surgical procedure or dialysis. To locate a Preferred provider, visit www.fepblue.org/provider use our National Doctor & Hospital Finder, or call us at the customer service number on the back of your ID card;
- For all other outpatient services by Non-member facilities, and for outpatient surgical services resulting from a medical emergency or accidental injury that are billed by Non-member facilities, our allowance is the billed amount (minus any amounts for noncovered services);
- For physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greater of (1) the Medicare participating fee schedule amount or the Medicare Part B Drug Average Sale Price (ASP) for the service, drug, or supply in the geographic area in which it was performed or obtained or (2) 100% of the Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained. Local Plans determine the UCR amount in different ways. In the absence of a Medicare participating fee schedule amount or ASP for any service, drug, or supply, our allowance is the Local Plan's UCR amount. In the absence of a Local Plan UCR amount, our allowance is 60% of the billed charge. Contact your Local Plan if you need more information. We may refer to our allowance for Non-participating providers as the "NPA" (for "Non-participating Provider Allowance");
- For emergency medical services performed in the emergency department of a hospital provided by physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greatest of (1) the Medicare participating fee schedule amount or the Medicare Part B Drug Average Sale Price (ASP) for the service, drug, or supply in the geographic area in which it was performed or obtained; or (2) 100% of the Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained; or (3) an allowance based on equivalent Preferred provider services that is calculated in compliance with the Affordable Care Act;
- For prescription drugs furnished by retail pharmacies that do not contract with CVS Caremark, our allowance is the average wholesale price ("AWP") of a drug on the date it is dispensed, as set forth by Medi-Span® in its national drug data file; and
- For services you receive outside of the United States, Puerto Rico, and the U.S. Virgin Islands from providers that do not contract with us or with AXA Assistance, we use our Overseas Fee Schedule to determine our allowance. Our fee schedule is based on a percentage of the amounts we allow for Non-participating providers in the Washington, DC, area.

Important notice about Non-participating providers!

Note: **Using Non-participating or Non-member providers could result in your having to pay significantly greater amounts for the services you receive.** Non-participating and Non-member providers are under no obligation to accept our allowance as payment in full. If you use Non-participating and/or Non-member providers, you will be responsible for any difference between our payment and the billed amount (except in certain circumstances involving covered Non-participating professional care – see below). In addition, you will be responsible for any applicable deductible, coinsurance, or copayment. You can reduce your out-of-pocket expenses by using Preferred providers whenever possible. To locate a Preferred provider, visit www.fepblue.org/provider to use our National Doctor & Hospital Finder, or call us at the customer service number on the back of your ID card. We encourage you to always use Preferred providers for your care.

Note: For **certain** covered services from Non-participating professional providers, your responsibility for the difference between the Non-participating Provider Allowance (NPA) and the billed amount may be limited.

In **only** those situations listed below, when the difference between the NPA and the billed amount for covered Non-participating professional care is greater than $5,000 for an episode of care, your responsibility will be limited to $5,000 (in addition to any applicable deductible, coinsurance, or copayment amounts). An episode of care is defined as all covered Non-participating professional services you receive during an emergency room visit, an outpatient visit, or a hospital admission (including associated emergency room or pre-admission services), plus your first follow-up outpatient visit to the Non-participating professional provider(s) who performed the service(s) during your hospital admission or emergency room visit.

- When you receive care in a Preferred hospital from Non-participating professional providers such as a radiologist, anesthesiologist, certified registered nurse anesthetist (CRNA), pathologist, neonatologist, or pediatric sub-specialist; and the professional providers are hospital-based or are specialists recruited from outside the hospital either without your knowledge and/or because they are needed to provide immediate medical or surgical expertise; and
- When you receive care from Non-participating professional providers in a Preferred, Member, or Non-member hospital as a result of a medical emergency or accidental injury (see pages 93-96).

For more information, see *Differences between our allowance and the bill* in Section 4. For more information about how we pay providers overseas, see page 32 and page 123.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Precertification

The requirement to contact the local Blue Cross and Blue Shield Plan serving the area where the services will be performed before being admitted for inpatient care. Please refer to the precertification information listed in Section 3.

Preferred provider organization (PPO) arrangement

An arrangement between Local Plans and physicians, hospitals, health care institutions, and other covered health care professionals (or for retail pharmacies, between pharmacies and CVS Caremark) to provide services to you at a reduced cost. The PPO provides you with an opportunity to reduce your out-of-pocket expenses for care by selecting your facilities and providers from among a specific group. PPO providers are available in most locations; using them whenever possible helps contain health care costs and reduces your out-of-pocket costs. The selection of PPO providers is solely the Local Plan's (or for pharmacies, CVS Caremark's) responsibility. We cannot guarantee that any specific provider will continue to participate in these PPO arrangements.

Pre-service claims

Those claims (1) that require precertification or prior approval, and (2) where failure to obtain precertification or prior approval results in a reduction of benefits.

Preventive care, Adult

Adult preventive care includes the following services: preventive office visits and exams [including health screening services to measure height, weight, blood pressure, heart rate, and Body Mass Index (BMI)]; chest X-ray; EKG; general health panel; basic or comprehensive metabolic panel; fasting lipoprotein profile; urinalysis; CBC; screening for diabetes mellitus, hepatitis B and hepatitis C; screening for alcohol/substance abuse; counseling on reducing health risks; screening for depression; screening for chlamydia, syphilis, gonorrhea, HPV, and HIV; administration and interpretation of a Health Risk Assessment questionnaire; cancer screenings including low-dose CT screening for lung cancer; screening for abdominal aortic aneurysms; and osteoporosis screening, as specifically stated in this brochure; and routine immunizations as licensed by the U.S. Food and Drug Administration (FDA).

Prior approval

Written assurance that benefits will be provided by:

1. The Local Plan where the services will be performed; or
2. The Retail Pharmacy Program, the Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program.

For more information, see the benefit descriptions in Section 5 and *Other services* in Section 3, under *You need prior Plan approval for certain services*, on pages 22-24.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Repatriation

The act of returning to the country of birth, citizenship or origin.

Routine services

Services that are not related to a specific illness, injury, set of symptoms, or maternity care (other than those routine costs associated with a clinical trial as defined on pages 75 and 137).

Screening service

An examination or test of an individual with no signs or symptoms of the specific disease for which the examination or test is being done, to identify the potential for that disease and prevent its occurrence.

Sound natural tooth

A tooth that is whole or properly restored (restoration with amalgams or resin-based composite fillings only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.

Specialty drugs

Pharmaceutical products that are included on the Service Benefit Plan Specialty Drug List that are typically high in cost and have one or more of the following characteristics:

- Injectable, infused, inhaled, or oral therapeutic agents, or products of biotechnology
- Complex drug therapy for a chronic or complex condition, and/or high potential for drug adverse effects
- Specialized patient training on the administration of the drug (including supplies and devices needed for administration) and coordination of care is required prior to drug therapy initiation and/or during therapy
- Unique patient compliance and safety monitoring requirements
- Unique requirements for handling, shipping, and storage

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from the carrier's health benefits plan.

Transplant period

A defined number of consecutive days associated with a covered organ/tissue transplant procedure.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our customer service department using the number on the back of your Service Benefit Plan ID card and tell us the claim is urgent. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We/Our

"Us," "we," and "our" refer to the Blue Cross and Blue Shield Service Benefit Plan, and the local Blue Cross and Blue Shield Plans that administer it.

You/Your

"You" and "your" refer to the enrollee (the contract holder eligible for enrollment and coverage under the Federal Employees Health Benefits Program and enrolled in the Plan) and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA) –** Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician-prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

  Note: If you are enrolled in the HCFSA, you can take advantage of the Paperless Reimbursement option, which allows you to be reimbursed from your HCFSA without submitting an FSAFEDS claim. When the Blue Cross and Blue Shield Service Benefit Plan receives a claim for benefits, the Plan forwards information about your out-of-pocket expenses (such as copayment and deductible amounts) to FSAFEDS for processing. FSAFEDS then reimburses you for your eligible out-of-pocket costs – there's no need for a claim form or receipt! Reimbursement is made directly to your bank from your HCFSA account via Electronic Funds Transfer. You may need to file a paper claim to FSAFEDS in certain situations. Visit www.FSAFEDS.com for more information. FSAFEDS is not part of the Service Benefit Plan.

- **Limited Expense Health Care FSA (LEX HCFSA) –** Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

- **Dependent Care FSA (DCFSA) –** Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

- If you are a new or newly eligible employee, you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit **www.FSAFEDS.com** or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time.
TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants, and X-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for lenses, frames, and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website www.opm.gov/healthcare-insurance/dental-vision/. These sites also provide links to each plan's website, where you can view detailed information about benefits and Preferred providers.

How do I enroll?

You enroll on the internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY: 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility, or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY: 1-800-843-3557), or visit www.ltcfeds.com.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear. This Index is not an official statement of benefits.

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2016

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the $350 per person ($700 per Self Plus One or Self and Family enrollment) calendar year deductible. If you use a Non-PPO physician or other health care professional, you generally pay any difference between our allowance and the billed amount, in addition to any share of our allowance shown below.

Standard Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: Nothing for preventive care; 15%* of our allowance; $25 per office visit for primary care physicians and other health care professionals; $35 per office visit for specialists Non-PPO: 35%* of our allowance	39-40, 42-47
Services provided by a hospital:		
• Inpatient	PPO: $350 per admission Non-PPO: $450 per admission, plus 35% of our allowance	80-82
• Outpatient	PPO: 15%* of our allowance Non-PPO: 35%* of our allowance	83-86
Emergency benefits:		
• Accidental injury	PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: Any difference between the Plan allowance and billed amount for outpatient hospital and physician services within 72 hours; regular benefits thereafter Ambulance transport services: Nothing	93-95, 97
• Medical emergency	PPO urgent care: $30 copayment; PPO and Non-PPO emergency room care: 15%* of our allowance; Regular benefits for physician and hospital care* provided in other than the emergency room/PPO urgent care center Ambulance transport services: $100 per day for ground ambulance (no deductible); $150 per day for air or sea ambulance (no deductible)	93, 95-97
Mental health and substance abuse treatment	PPO: Regular cost-sharing, such as $25 office visit copay; $350 per inpatient admission Non-PPO: Regular cost-sharing, such as 35%* of our allowance for office visits; $450 per inpatient admission to Member facilities, plus 35% of our allowance	98-101
Prescription drugs	Retail Pharmacy Program: • PPO: 20% of our allowance generic (15% if you have Medicare)/ 30% of our allowance preferred brand-name/45% of our allowance non-preferred brand-name • Non-PPO: 45% of our allowance (AWP) Mail Service Prescription Drug Program: • $15 generic ($10 if you have Medicare)/$80 preferred brand-name/ $105 non-preferred brand-name per prescription; up to a 90-day supply Specialty Drug Pharmacy Program: • See inside for details	102-114

Standard Option Summary – continued on next page

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2016 *(continued)*

Dental care	Scheduled allowances for diagnostic and preventive services; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	70, 115-117
Special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor & Hospital Finder℠; Healthy Families; *WalkingWorks*® Wellness Program; travel benefit/services overseas; Care Management Programs; and Flexible benefits option		119-122
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	• Self Only: Nothing after $5,000 (PPO) or $7,000 (PPO/Non-PPO) per contract per year • Self Plus One: Nothing after $10,000 (PPO) or $14,000 (PPO/Non-PPO) per contract per year • Self and Family: Nothing after $10,000 (PPO) or $14,000 (PPO/Non-PPO) per contract per year ***Note:*** Some costs do not count toward this protection. ***Note:*** When one covered family member (Self Plus One and Self and Family contracts) reaches the Self Only maximum during the calendar year, that member's claims will no longer be subject to associated member cost-share amounts for the remainder of the year. All remaining family members will be required to meet the balance of the catastrophic protection out-of-pocket maximum.	32-33

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2016

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Basic Option does not provide benefits when you use Non-preferred providers. For a list of the exceptions to this requirement, see page 21. There is no deductible for Basic Option.

Basic Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: Nothing for preventive care; $30 per office visit for primary care physicians and other health care professionals; $40 per office visit for specialists Non-PPO: You pay all charges	39-40, 42-47
Services provided by a hospital:		
• Inpatient	PPO: $175 per day up to $875 per admission Non-PPO: You pay all charges	80-82
• Outpatient	PPO: $100 per day per facility Non-PPO: You pay all charges	83-86
Emergency benefits:		
• Accidental injury	PPO: $35 copayment for urgent care; $125 copayment for emergency room care Non-PPO: $125 copayment for emergency room care; you pay all charges for care in settings other than the emergency room Ambulance transport services: $100 per day for ground ambulance; $150 per day for air or sea ambulance	93-95, 97
• Medical emergency	Same as for accidental injury	93, 95-97
Mental health and substance abuse treatment	PPO: Regular cost-sharing, such as $30 office visit copayment; $175 per day up to $875 per inpatient admission Non-PPO: You pay all charges	98-101
Prescription drugs	Retail Pharmacy Program: • PPO: $10 generic/$50 preferred brand-name per prescription ($45 if you have primary Medicare Part B)/60% coinsurance ($65 minimum) for non-preferred brand-name drugs (50% ($55 minimum) if you have primary Medicare Part B) • Non-PPO: You pay all charges Specialty Drug Pharmacy Program: • See inside for details Mail Service Prescription Drug Program (for primary Medicare Part B members only): $20 generic/$90 preferred brand-name/$115 non-preferred brand-name per prescription; up to a 90-day supply	102-114
Dental care	PPO: $30 copayment per evaluation (exam, cleaning, and X-rays); most services limited to 2 per year; sealants for children up to age 16; $30 copayment for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	70, 115-116, 118
Special features: Health Tools; Blue Health Assessment; MyBlue® Customer eService; Diabetes Management Incentive Program; National Doctor & Hospital Finder℠; Healthy Families; *WalkingWorks*® Wellness Program; travel benefit/services overseas; Care Management Programs; and Flexible benefits option		119-122

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2016 *(continued)*

Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	• Self Only: Nothing after $5,500 (PPO) per contract per year • Self Plus One: Nothing after $11,000 (PPO) per contract per year • Self and Family: Nothing after $11,000 (PPO) per contract per year; nothing after $5,500 (PPO) per individual per year ***Note:*** Some costs do not count toward this protection. ***Note:*** When one covered family member (Self Plus One and Self and Family contracts) reaches the Self Only maximum during the calendar year, that member's claims will no longer be subject to associated member cost-share amounts for the remainder of the year. All remaining family members will be required to meet the balance of the catastrophic protection out-of-pocket maximum.	32-33

2016 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment.

Postal rates apply to Postal Service employees. They are shown in special Guides published for APWU (including Material Distribution Center and Operating Services), NALC, NPMHU, and NRLCA Career Postal Employees (see RI 70-2A); Information Technology/Accounting Services employees (see RI 70-2IT); Nurses (see RI 70-2N); Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees and Postal Career Executive Service employees (see RI 70-2IN); and non-career employees (see RI 70-8PS).

Postal rates apply to United States Postal Service employees.

Postal Category 1 rates apply to career employees who are career bargaining unit employees.

Postal Category 2 rates apply to career non-bargaining unit employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center
1-877-477-3273, option 5
TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees.

Premiums for Tribal employees are shown under the monthly non-postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Standard Option Self Only	**104**	**$213.37**	**$100.18**	**$462.30**	**$217.06**	**$88.32**	**$100.18**
Standard Option Self Plus One	**106**	**$461.02**	**$231.31**	**$998.88**	**$501.17**	**$205.70**	**$231.31**
Standard Option Self and Family	**105**	**$488.50**	**$238.24**	**$1,058.42**	**$516.18**	**$211.10**	**$238.24**
Basic Option Self Only	**111**	**$205.46**	**$68.48**	**$445.16**	**$148.38**	**$56.84**	**$68.48**
Basic Option Self Plus One	**113**	**$461.02**	**$160.75**	**$998.88**	**$348.29**	**$135.14**	**$160.75**
Basic Option Self and Family	**112**	**$488.50**	**$164.20**	**$1,058.42**	**$355.76**	**$137.06**	**$164.20**